Focal Family Therapy: Joining Systems Theory with Psychodynamic Understanding

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Reprinted from: HANDBOOK OF FAMILY THERAPY, Vol. II
edited by Alan S. Gurman, Ph.D. and David P. Kniskern, Psy.D.
New York: Brunner/Mazel Inc. 1991

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HISTORICAL PERSPECTIVE

Psychoanalytic Origins of Family Therapy

Family therapy arose out of psychoanalysis and psychoanalytically informed thinking. The early pioneers were either psychoanalysts themselves (e.g., Ackerman [1958], Wynne [1965], Lidz [1963], Stierlin [1977]), or were closely involved with psychoanalysis (e.g., Dicks [1967], Skynner [1976], Boszormenyi-Nagy & Framo [1965]). Some of the pioneers continued to practice an approach that was clearly allied with psychoanalytic work, whereas others repudiated their origins.

In the United Kingdom, the emergence of psychoanalytic theories of individual emotional development created a context in which it was easier for family therapy to maintain links with the psychoanalytic tradition. The "controversial discussions" in the 1940s were generated by Melanie Klein's (Klein, 1949) work on primitive object relations, and those led to a gap between the United Kingdom and the United States with regard to psychoanalytic conceptions. Psychoanalytic schools of thought in the United Kingdom emphasized the role of the emotional environment and the importance of relationships with the mother and the family (Bowlby, 1949; Winnicott, 1964).

The awareness of the traumatic impact of World War II and the Holocaust on individuals and families also proved to be an important influence on psychoanalytic thinking. In addition, work in the United States at this time by Bettelheim (1950) and Erikson (1963) emphasized the influential role of the family and social en-

vironment, but their contribution never became part of the American mainstream of psychoanalytic theorizing. Early American family therapists such as Jackson (1959), even while breaking with the American version of psychoanalytic theory, recognized that British reformulations such as that provided by Fairbairn (1949) could be seen as a bridge between intrapsychic therapy and family therapy. Further developments and applications of object relations theory in the United Kingdom proved successful in the field of marital work (Dicks, 1967), general practice (Balint, 1964), and hospital practice (Main, 1957). In each case, it was noted that disturbance in a person is invariably linked to relationship problems with key others in the immediate social context.

Balint and colleagues (Balint, Balint, & Ornstein, 1972), in a piece of brief therapeutic work, predicted correctly that the patient's partner would come in with the patient as the therapy progressed, and the therapist then worked with the couple as part of the psychotherapeutic work with the individual. Group analysis in the United Kingdom was a product of psychoanalysis, and was dominated in the early years by psychoanalysts (Foulkes, 1973). The application of object relations theory to group psychotherapy by Ezriel (1956), Bion (1961), and Turquet (1975) also paved the way to a move from an approach that saw a therapeutic group taking up various family roles to one that saw those same roles in the family itself. Skynner (1976) developed family therapy in this way. Skynner initially worked with the family as a special form of group, a family group as distinct from a stranger group, but soon came to see the family as a unique institution. The eventual move from seeing the family rather than the individual as the focus of work was then a small step.

Our own development began in psychoanalysis and hospital psychiatry, included the use of group therapy, and then moved to a deep and ongoing involvement in family therapy. We continue to work in all three fields.

Recent theoretical developments have brought psychoanalytic thinking even closer to the concerns of family therapists, and vice versa. A prime theoretic issue within psychoanalysis in recent decades has been that of narcissism and observations, concepts, and modes of intervention that arise from narcissistic pathology.

Early psychoanalytic writers, following Freud, had established that narcissism referred both to a person's sense of self and to a form of relationship in which that self was determined by or lost within the other (Andreas-Salome, 1962). These two notions led to the development of two separate streams of theory and technique. Kleinian writers saw narcissism as a self-protective mode of relating in which separateness is denied, the object is destroyed, and the emotional, dependent, needy part of the person is deprived of support and emotional nourishment (Rosenfeld, 1964; Kernberg, 1975). More classical analysts saw narcissism as concerned with the self-representation and its integration, continuity, and valuation (Stolorow, 1975). Such an approach to narcissism was further developed by Kohut (1971).

These psychoanalytic ideas have been taken up by one of us in associated research that has been much influenced by our study of the family. The relation between the classical self-orientated approach to narcissism ("self-narcissism") and the Kleinian object-orientated approach ("object narcissism") was clarified by Kinston (1982, 1983a, 1983b), and the relation of narcissism to repression and trauma has been clarified by Kinston and Cohen (1984, 1986, 1988). This work demonstrated that traumatic handling of the child in the family leads both to a negative valuation of the self owing to the associated nonrecognition or rejection of the child's inner core and to the development of an object-narcissistic shell to ensure physical and psychic survival. Trauma, therefore, imprints an identity on the individual and is the basis for the repetition of relationships in social life and for the occurrence of catastrophic events in life and therapy (Cohen & Kinston, 1989a).[1]

Object-narcissism manifests in three forms: as collusive pseudorelatedness (noted as the "false self" in Winnicott's writings), as apparent nonrelatedness (the "stone wall" of narcissism), or

[1] *Editors' Note.* The discussion that precedes and follows is extremely significant, as it represents one of the few considerations of the role of trauma to appear in "mainstream" family-therapy literature. In this way, this chapter, while grounded, in part, in psychodynamic thought, reflects a genuine effort at theoretical and clinical integration, bringing together, as it does, the intrapsychic, the interpersonal, and the transactional.

as need-driven malrelatedness (i.e., scripts or games) (Kinston & Cohen, 1988). In other words, its features are as overtly relational as intrapsychic. When the relationships are modified and object-narcissism abandoned, then the underlying trauma presents and physical, psychological, and social deterioration result (Cohen & Kinston, 1989a).

This psychoanalytic research, complementing our family research, has focused more and more on the therapist–patient relationship as a new health-promoting endeavor. A new relationship is needed to repair the trauma that persists as a "hole in the mind," and that is the source of defenses and pathological relating. The role of trauma, although emphasized by Freud, frequently has been bypassed by modern psychoanalysts, by many psychiatrists, by most family therapists, and by society as a whole. The upsurge of traumatic stress disorders in association with the Vietnam war and civil disasters, however, has increased the awareness and attention of psychiatrists (Kinston & Rosser, 1974). Physical and sexual abuse of children and marital violence are also starting to make family therapists aware of the long-term consequences of traumatic events for thinking and behavior patterns (Bentovim, 1990).

It is worth noting that the role of trauma was recognized in the early days of family therapy (Jackson, 1957), but appears to have been ignored in subsequent theories and techniques. The reason for this may lie in the fact that trauma is a one-way event and not alterable via punctuation. It brings to the fore issues of responsibility, power, inequalities among family members, and the place of social reality—all notions alien to much family therapy (as well as psychoanalytic) thinking.

Psychoanalysis and Family Therapy Today

When we look at the role of psychoanalysis in family therapy today, a variety of pictures are identifiable. One approach is to involve all family members in individual psychotherapy or psychoanalysis. Another approach involves seeing the whole family together and giving interpretations to it as an entity with the main stress being placed on transference and countertransference experiences and fantasies. In this approach, the flow of the material in sessions and the issues to be tackled may be left to the family to bring up spontaneously, reminiscent of the method of free association (Box, Copley, Magagna, & Moustaki, 1981; Zinner & Shapiro, 1974). Various approaches have been developed by therapists whose practice no longer can be designated "psychoanalytic" but who have picked out a major area of family–emotional life on which to focus, and whose psychoanalytic origin is unmistakable. For example, Bowen (1976) and Framo (1976) are particularly concerned with intergenerational issues and individuation, and Boszormenyi-Nagy and Spark (1973) with the issues of family loyalties, justice, and fairness.

In contrast to these various approaches, but perhaps closest to the last group, it is our stance to continue to draw on the knowledge and spirit of psychoanalysis while remaining true to our understanding of the nature of family functioning and pathology and the distinctive interventions that flow from these. Our work, therefore, aims to contribute to the development of both family theory and psychoanalytic theory.

Our initial foray into the family field was stimulated by the brief focal therapy with individuals as developed by Balint and Malan at the Tavistock Clinic (Malan, 1963, 1976). Their approach was based on the view that if one understood the individual's core conflict, it would be unnecessary to do prolonged intensive work. Winnicott (1971) had shown that brief intensive consultations with children could provide a therapeutic encounter with the patient that often unlocked long-standing obstacles to change. These findings ran counter to the dogmatically held belief that change could only occur as the result of long-term work.

The essence of these therapeutic developments was the abandonment of slavish adherence to prescriptions as to what constituted a proper method of intervention. The early family therapists in the United States also noted that a wide variety of methods appeared to be effective when applied to families. Ferber and associates (Ferber, Mendelsohn, & Napier, 1973) commented that the theories legitimizing such new methods appeared to be little more than a rationalization for the interventions. Madanes and Haley (1979) made the useful distinction between therapies oriented to methods—such as

the structured approach to anorexia nervosa that should always include a family meal, definition of roles, and so on—and approaches catering to the needs of a particular case. The Mental Research Institute's Brief Therapy approach is one in which the nature of the intervention is not known in advance.

In a similar fashion, rather than expecting theory to legitimize methods, we expect the needs of the family to legitimize what we do. In other words, we have taken a pragmatic approach and have assimilated virtually all methods that have emerged in family therapy over the past 20 years. The needs of the family are defined by the theory we develop for each family. Without knowing it at the time, we had stumbled on a genuinely systemic conception (Kinston & Algie, 1989). Haley (1977) made the important observation that a formulation must precede intervention because it was possible to make a formulation—for example, of an "irresolvable symbiotic tie between child and mother"—that defined intervention as impossible. Our psychoanalytically oriented view similarly assumed that a suitable formulation of family life would point the way to therapeutic action. An important task, therefore, was to conceptualize the general nature of such a formulation.

Although many concrete aspects of psychoanalytic treatment could not be transferred to working with the family, certain broader principles were. Indeed, nonanalytic family therapists in many cases have been rediscovering the wheel. Intense opposition to change is a longstanding psychodynamic principle. Another is deterioration in functioning once the core disturbance is approached. Just as verbal or intellectual insight in psychoanalysis is meaningless or of limited value, we would expect the same to apply in family therapy. However, the therapeutic focus on altering patterns of action and meaning fixed by past trauma is generally a new idea for family therapists.

Development of Our Approach

Whereas a good deal of the early development of family therapy in the United States focused on schizophrenia, the development of family work in the United Kingdom began almost exclusively in child-guidance and child psychiatric clinics.[2] The emotional and behavioral disturbances in a child psychiatric practice are amenable to a psychoanalytic approach, in contrast to schizophrenia, which is relatively inaccessible. In order to apply psychodynamic thinking to family work in this service context, we set up research that had three main objectives:

1. To develop our capacity to see the family as an entity with its own life and meanings.
2. To discover ways of eliciting family interaction clinically and systematically.
3. To learn how to describe and assess family interactions in terms that are clinically meaningful and not entirely based on descriptions of individuals.

We established a workshop in 1973 to apply Malan's method of brief focal psychotherapy to families, and this work was reviewed and written up after two years (Bentovim & Kinston, 1978; Kinston & Bentovim, 1978). We became aware from that review that our methods of diagnostic interviewing and of formulating family dysfunction required improvement. Our ways of assessing process and evaluating change also required attention. Further workshops then followed, and are still ongoing, to examine these problems with clinicians and develop the methods. The methods have also been applied to specific target groups, such as families with a child who needs to go into care (Bentovim & Gilmour, 1981) or with a child who has suffered physical or sexual abuse (Bentovim, 1990).

Methods of systematic description and assessment were pursued simultaneously (Kinston, Loader, & Stratford, 1979; Loader, Burck, Kinston, & Bentovim, 1981; Miller, Loader, & Kinston, 1984). Ways of eliciting clinically relevant interaction other than in the therapeutic context were also required. A standardized method of clinical interviewing was devised (Kinston & Loader, 1984, 1986) and the task-interview approach introduced by others was improved (Kinston, Loader, & Miller, 1988a; Kinston, Loader, Miller, & Rein, 1988b). These

[2] *Editors' Note.* While the origins of American family therapy certainly did involve the treatment of schizophrenia, a separate generative thread in the early clinical scene also involved the child-guidance movement.

methods have also been applied to specific target groups, including obese children (Kinston, Loader, & Miller, 1987a, 1987b; Kinston et al., 1988a, 1988b) and school refusers (Huffinton & Sevitt, 1989).

Throughout this period, we have shared our approach with colleagues using videotaped material to show that it is possible to describe and assess family functioning through the approaches developed and to create an appropriate theory of the core disturbance in relationship to a particular family. We have worked to demonstrate that it can be done reliably. As we have already indicated, we regard it as a matter of principle (and a fundamental postulate of the systems approach) that methods of intervention are secondary to an understanding of the family. In confirmation, we have found that, in general, the increasing sophistication of interventions in the family-therapy field over the past decade has been integrated into our daily therapeutic work without difficulty.

Describing the Family

We now must turn to the question of how to describe the family in its context and how to describe the family itself. The family attends because its members perceive a problem either with one of them, or occasionally with family functioning, or because someone else perceives a difficulty and makes a referral. Our approach refuses to focus on the problem as perceived by the family alone, or by the referrer, but attempts to put the problem into its appropriate context. The assessment of any family provides a cross-sectional snapshot that must be placed in the context of the phase of its life cycle and of its social and general historical situation.

We have developed a general theory of symptom formulation from family research into childhood obesity (Kinston, 1987), which is based on a simple social-systems model (see Figure 9-1). The social system comprises the individual, the family, and society as its key elements, each of which is a system. The experiences that define society, families, and individuals are distinct but dependent on each other. Society's experiences are defined in terms of attitudes, norms, rights, and values. These persist largely through the family, which serves as the agent that transmits and reproduces culture. The family depends on the societal context for support and legitimization and for its own sense of value. The family's experiences are defined in terms of its own interactions and meanings and it is itself reproduced by individuals in the family, since individuals are nurtured and socialized by the family. At the same time, individuals create and regulate the interactions and meanings within the family. The circle is completed as individuals confirm or react to (or, rarely, transform) society. At the same time, society recognizes and assigns value to individuals through their activities and achievements.

This is a completely systemic view. Despite claims to the contrary, the majority of family therapists largely ignore society and concern themselves with interactions between the family and individual members, with varying degree of emphasis on the family as a whole, or on the individual member, or on the interaction between the two.[3] Those who note the role of society tend to gravitate to political action rather than to therapy. At this stage, we, too, have taken a limited view of societal experience and will not be reporting on our steps to include this component. Because we treat families within the U.K. National Health Service, our work is legitimized through social structures and so involves certain societal statutory responsibilities. This becomes particularly evident when we work with families that have transgressed societal boundaries, for example, with respect to violence or where failure to care for a child requires the child's removal from the family.

A SEVEN-LEVEL DESCRIPTION OF FAMILY FUNCTIONING

When we came to evaluate our initial attempts to work with families (Kinston & Bentovim, 1978), we soon discovered that the family field

[3] *Editors' Note.* We agree fully with this observation, and we believe it is accurate because, in the end, the place in the lives of families where family therapists have the greatest therapeutic (i.e., change-inducing) leverage is within the family, not between the family and its society or culture.

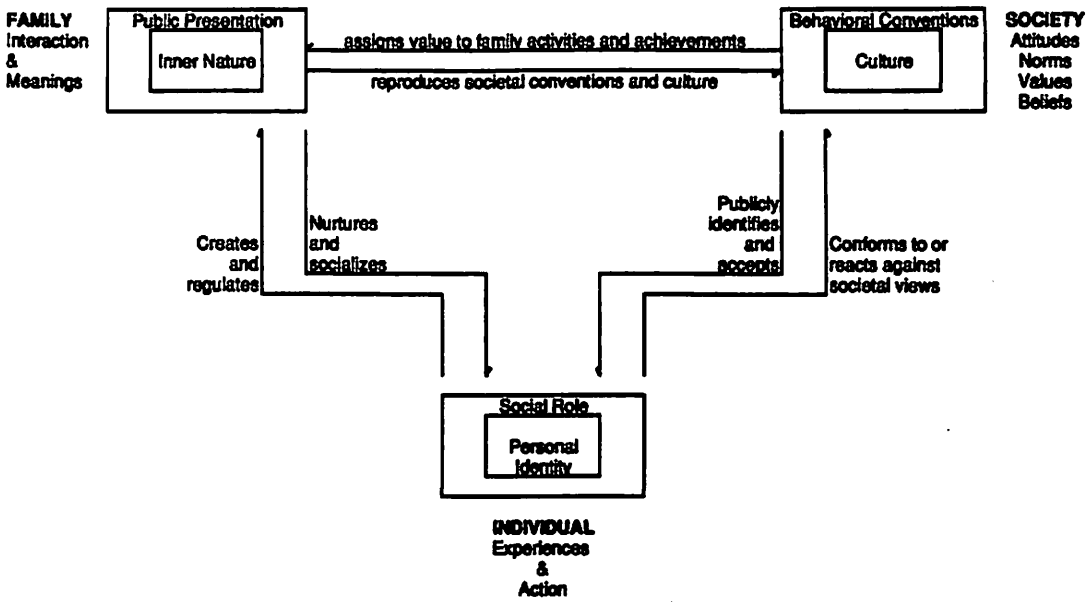

Figure 9-1.

lacked a coherent system for describing families. We found ourselves using many concepts, but we realized that we used these in a somewhat arbitary and unsystematic way. It has now become clear to us (Kinston & Bentovim, 1990) that family functioning requires description on seven distinct levels, hierarchally arranged.

Level 1. Concepts of Interaction

Level 1 descriptions are the concepts or ideas about family interaction and family life without which the simplest objective description, let alone the necessary complex account required for therapy, is utterly impossible. Without concepts to organize observation, a family interview is a complex jumble of phenomena and the observer feels lost and unable to know how and where to direct his or her attention.

Concepts applicable to the description of families may be either elemental or global. An elemental concept might be "interruption," "laughter," or "direct agreement." Examples of global concepts are "boundaries" and "parenting." Both forms are taken to be self-evident and assumed to be enduring features of family interaction. Such concepts can be ordered in terms of levels or aggregated with others, so that, for example, "interruption" is part of "continuity," which could be aggregated with "clarity" and "responsiveness" and other qualities to form the conceptual domain of communication. It is possible to analyze communication in other ways, for example, into subdomains of pragmatics, semantics, and syntactics (Watzlawick et al., 1967).

Domains used in the family-therapy field have been identified and analyzed. For instance, Loader and co-workers (Loader et al., 1981) and Kinston and co-workers (Kinston et al., 1987a, 1987b) list the main domains as the affective life of the family, communication, boundaries, alliances, adaptability and stability of family organization, and competence for family tasks, and they subdivided each into subdomains. We later describe these concepts in more detail.

Concepts become part of the expert's specialized language and are important for any comparison of families. Therapists must, however, apply them to particular families and must validate their constructs empirically to the satisfaction of their colleagues as well as of outsiders. In any case, therapy requires realities to alter, and to appreciate realities it is necessary to focus

on actual events in detail. This takes us to the second level.

Level 2. Items of Interaction

These are the actual concrete items of interaction and the simplest account of things or events that are clinically recognizable in a particular case. The event may be either verbal or nonverbal—for example, an actual interruption, a particular hostile gesture, an identifiable agreement or disagreement, a given promise. As with concepts, these descriptions are not simple or elemental in any absolute sense. For example, the hostile gesture would be made up of a vast number of bodily movements. Clinicians require descriptions at a certain level of complexity that is sufficient to contain a basic quantum of clinical meaning.

Items can be evaluated as good or bad according to prejudice or social convention, but no judgment can be made as to whether an item taken on its own is functional or dysfunctional in the total family context. Indeed, when stripped of context, items make little sense.

Level 3. Episodes of Interaction

Level 3 descriptions are necessary because, although elements are the fundamental clinical building blocks of description, both concepts and items need to be organized into episodes that involve the whole family. An episode is an actual combination that has an inherent completeness and a coherence in time. For example, an episode might consist of all the elemental interactions (and the associated underlying concepts) required to describe a family meeting to plan an outing. An episode in the Z. family in therapy could be specified as follows: the father starts talking to the mother, who withdraws into silence; the father then criticizes their infant daughter; the mother joins in criticizing; and the father becomes silent before once again addressing the mother.

This level of description is referred to by Keeney and Ross (1985) as the "political frame of reference." Episodes have also been termed cycles or sequences. Dysfunction cannot be assessed from a single episode, but the identification and description of an episode are pregnant with implications for family functioning. This level of description is so universally emphasized that it is frequently (but incorrectly, in our view) regarded as inherently definitive of a systemic approach.

From a clinical point of view, episodes are sufficiently contextualized to make sense on their own. They link into the realities of family life and, therefore, communicate in a way that descriptions at a lower level do not. However, clinicians feel the urge to put any given episode into the context of other episodes, similar or different; in other words, to move up one more level in the framework.

Level 4. Patterns of Meaning

Level 4 descriptions produce patterns of meaning by placing family episodes in context. This level of description is referred to by Keeney and Ross (1985) as the "semantic frame of reference."

A clear judgment about the existence of dysfunction can now be made from a single account. For example, the family referred to above may plan an outing in a way that seems competent and reasonable. However, if such plans routinely are made and never carried out, or if the outings typically end in disaster, then the episode in the family is seen in a larger perspective and would be properly judged to be evidence of dysfunction.

Episodes may be reflexively put into their own context and family therapists focus particularly on episodes that regularly repeat or recycle. Such dysfunctional episodes feed back on themselves, occur without provocation, and become the primary preoccupation in family life (Kinston & Bentovim, 1981).

The salient context at level 4 is general and has no predefined limit. As the context of a relevant event or episode enlarges, deeper and more complex meanings emerge. For example, the repeated pattern of criticizing a child to generate togetherness in the Z. family would take on a different meaning if the mother had suffered physical abuse as a child than it would if the parents had had a lengthy separation following the birth of their child.

In principle, therefore, any and all perspec-

tives can be brought to bear to bring out the fullest possible meaning of any actual episode. Very often, the meaning of any reality is to be found in the opposites that constitute it. Therefore, appreciating or reconciling such opposites is necessary. For example, if a particular episode is identified by the family or therapist as "disruptive," it is possible for it to be simultaneously identified as "cohesive." Such a way of deriving meaning long has been recognized by family therapists with labels such as "reframing" and "positive connotation."

Therapists, however, have a responsibility to intervene for the benefit of the family, and they must go beyond patterns of meanings to synthesize a model of the family as a whole, using all descriptions so far obtained. This leads to the next level.

Level 5. Holistic Formulation

Level 5 is a holistic formulation that provides a single complete account of the family as it is now. We see this as a systemic account of the family because it integrates lower-level descriptions, especially episodes (level 3) and their dysfunctional meanings (level 4). This account takes note of all relevant factors in generating a model of how the family works and can be used for intervention. Many family therapists extend or restrict the definition of relevant factors to a greater or lesser degree, while still claiming to use a family-systems approach.

To give a coherent explanation or a model of the way the Z. family works, we need to extend our inquiry. Having established that the parents come together through criticizing the child, and that the meaning pattern relates to the abuse of the mother as a child, we would need to bring these and other factors into play. Thus, we would consider interlocking patterns that draw a woman who has been abused in childhood to a particular marital partner, and vice versa; the stage in the marital relationship; the age of the child who triggered a particular response; the reasons why the case came to professional notice at a particular time; and so on. Examples of holistic formulation will be described in a number of different clinical contexts.

These five levels make up the actual levels, with the lower three relatively concrete and specific and the upper two more abstract and general. Two further levels of description exist that describe "ideal" or "theoretical" families. In one, the ideal is a type of family to which the actual family conforms to a greater or lesser degree. In the other, the ideal is a potential description the family may actualize.

Level 6. Type Formulation

Level 6 refers to the typing or categorization of the family based on one or more of its features that are considered characteristic. The aim of typing is to group together different families and to use this grouping for predictive purposes. This is required for a number of systematic activities, such as clinical policies, service planning, and adapting differentially to the needs of different groups. Such systematization may be required to enhance a therapeutic process, minimize costs, or support or orient the staff. Type description is appropriately regarded as "higher" because it encompasses and puts into perspective all descriptions at lower levels, and because it puts a family into the wider context of all families (Fisher, 1977). However, a family type requires substantial validation to be used by therapists, whose natural preference is for unique actual descriptions. At times, a type may become established by clinical lore—observations being distorted to fit postulated type characteristics.

Straightforward empirical approaches have used overt symptoms as a basis for type, for example, schizophrenic, delinquent, or multiproblem families. Olson and co-workers (Olson, Sprenkel, & Russell, 1979) have tried to use two dimensions, adaptability and cohesion, to classify families. Psychodynamic conceptions have also been applied, such as obsessional, phobic, or hysterical families. A more relevant attempt by Reiss (1981) based on paradigmatic forms of interaction of families with their environment has not penetrated clinical work substantially. Attempts have been made to test whether there is such an entity as the psychosomatic family (Minuchin, Rosman, & Baker, 1978). We have tried to base a clinical typology on the handling of traumatic events (Kinston & Bentovim, 1981). This will be presented later in the chapter.

Level 7. Requisite Formulation

Level 7 is an idealistic formulation. It is a conception of the family as it might be in the future if therapy is successful. All intervention has, by definition, some conception of a future for the family, even though this may be left indefinite or implicit. Level 1 and level 4 assessments of dysfunction, for example, are based on the violation of certain ideas of healthy interaction. In making such an assessment, an implicit description of appropriate function is being assumed. Deliberately thinking sytemically about what is possible for the family may lead to a useful consideration of the constructive contribution of other agencies, networks, or treatments, even if such issues have not emerged in descriptions prior to this level.

For a holistic–systemic approach, the level 7 description is an ideal future scenario that takes all relevant realities, including family and therapist values, into account. In order to make such an assessment without blocking a family or setting themselves and the family an impossible task, therapists need to have the widest possible imaginative and theoretical access to the family, to themselves, and to conceptions of family operation.

We have found that our focal family-therapy model requires satisfactory descriptions on all lower levels in order to derive a satisfactory level 7 description. Other family-therapy approaches do not take the same view (Kinston & Bentovim, 1990). For example, behavior therapists concentrate on concrete items (level 2) and observation of episodes (level 3) while ignoring patterns of meaning (level 4) and a holistic account (level 5). The Milan approach emphasizes the need for a holistic account (level 5), but denies the value of a requisite formulation (level 7) or typologies (level 6).

We have also found it necessary to appreciate the variety of different dimensions (level 1), rather than being locked into any single one of them. It is necessary, as well, to find ways of appreciating the immediate and longer-term historical contexts to enable us to make sense of family behavior at level 3. It was, of course, essential to be able to recognize items of interaction (level 2) and to combine them into episodes or cycles (level 3). The higher levels (levels 6 and 7) have also proved necessary for rational therapy and for our clinical research. We will look at the various levels in more detail.

THE CONCEPTS AND ITEMS OF FAMILY LIFE

To help us describe families, we developed formats and procedures. Concepts of interaction were examined in early work (Kinston et al., 1979) and these were later organized and elaborated using dimensions of family functioning in the Family Health Scales (see Figure 9-2 and Kinston et al., 1987a) and the Summary Format of Family Functioning (Loader et al., 1981; Miller et al., 1984).

Concepts of family health were invariably seen to vary as dimensions from optimal through adequate to dysfunctional and then breakdown (Kinston et al., 1987a, 1987b; Lewis, Beavers, Gossett, & Phillips, 1976), and this occurred because values had been built in at level 3. We will now give a brief description of interactions described under each of the conceptual-domain headings. Each domain has the aspects best described in family cultural terms, in relationship terms, and in individual terms.

The Family Health Scales

Affective Life

Emotional aspects of family life include family atmosphere as a cultural feature, the nature and quality of emotional relationships within the family, and the degree and quality of emotional involvement, affective expression, and mood of family members. Family atmosphere may be described in such terms as comfort, warmth, harmony, safety, and humor, or, at the other extreme, as cold, uncomfortable, excited, dead, poisonous, panicky, chaotic, or claustrophobic. Relationships can be seen as perverse, attacking, unsupported, and inconsistent, or as facilitating, appreciative, and supportive. We can see emotional involvement as detached or overresponsive, emotionally intrusive or securely attached, and with or without understanding. Affective expression can be adequate, spontaneous, and

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
FAMILY ATMOSPHERE	Dead, chaotic, sense of panic, intense discomfort, claustrophobic.	Uncomfortable, cold, tense, unsafe, overexcited.	Basic sense of safety, but with some tensions.	Comfortable, vital, warm, harmonious, sense of safety, humor available.
NATURE OF RELATIONSHIPS	Perverse, attacking rejecting, devaluing, overdependent.	Unsupportive, unappreciative, inconsistent, undermining.	Relationships supportive but with some inconsistencies.	Affiliative, supportive, valuing, appreciative.
EMOTIONAL INVOLVEMENT	Absence of involvement or intense overinvolvement—positive or negative.	Detachment, overresponsiveness; emotional intrusiveness.	Attachment with marginal over- or underinvolvement.	Empathic relations: understanding without intrusion.
AFFECTIVE EXPRESSION	Feelings concealed or used manipulatively; expression of affect is overwhelming or absent.	Restricted range of emotions; impoverished, confusing, or inconsistent expression.	Adequate expression of feelings with some difficulties.	Clear, open, direct, spontaneous and sensitive; full range of emotions available.
INDIVIDUAL MOOD	Inappropriate affect and/or painful or negative emotions predominate.	Members are ill at ease, flat, depressed, overexcited.	Family members reasonably at ease with themselves and their family.	Prevailing mood of members is appropriate to the situation, sense of well-being.

Figure 9-2. Descriptors from the "affective life main scale" of the family health scales, which considers the emotional life of family members (From Kinston et al., 1987a)

sensitive, or feelings can be impoverished or concealed or used manipulatively. Emotions can also be confusing or inconsistent. Individual family members can be at ease with themselves, and experience a sense of well-being or be ill at ease, with dysphoric experiences and negative pessimistic imagery. (See Figure 9-2.)

Communication

The communication dimension includes the continuity of topics, the involvement of members of the family, and how messages are expressed and received. Communication can be severely fragmented and chaotic, there can be occasional disruption and blocks, or the family can share the focus of attention, with topics and themes developing naturally. All members may participate in conversations or a particular family member may dominate, or be withdrawn, or be excluded or ignored. Messages can be clear or confused and indistinct. There may be incongruence between verbal and nonverbal messages or indirect masked messages. Clarity may be mechanical or inhibited or messages may be delivered naturally and spontaneously. Messages may be heard with appropriate acknowledgment and response, or there may be lack of attentiveness or failure to acknowledge, or responses may be bizarre. (See Figure 9-3.)

Boundaries

In this dimension, we are concerned with the family's relationship to the environment, and with family cohesion, intergenerational boundaries, and individual autonomy. Families with a distinct identity and yet integrated with the outside world contrast with families that are suspicious and threatened, uninvolved, and overly self-sufficient, or cut off and insular. An optimal stage of individuation will be balanced with closeness, but family members may be generally isolated from one another or grossly overin-

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
CONTINUITY	Severe disruption, fragmented, chaotic communication, fixation on a topic.	Mechanical, disjointed, stuck; topics poorly sustained.	Occasional loss of continuity, but little disruption.	Ability to share a focus of attention; natural development of topics and themes.
INVOLVEMENT	Marked domination, severe withdrawal, active exclusion.	One or more members attempt to dominate or have difficulty in participating.	Minor degree of inequality of participation.	All members participate fully, as appropriate.
EXPRESSION OF MESSAGES	Indirect or masked messages; verbal/nonverbal incongruence; minimal verbal interchange.	Clarity impaired; expression is mechanical, inhibited, or confused.	Messages are generally clear, but sometimes meaning is uncertain or ambiguous.	Clear direct messages delivered naturally and spontaneously.
RECEPTION OF MESSAGES	Failure to listen, acknowledge, and respond, or bizarre responses.	Lack of attentiveness; inappropriate responsiveness.	Listening and acknowledgment are adequate with occasional lapses.	Members listen, acknowledge, and respond appropriately to one another.

Figure 9-3. Descriptors from the "communication main scale" of the family health scales, which considers verbal and nonverbal interchange among family members (From Kinston et al., 1987a)

volved. Instead of a well-defined but flexible and age-appropriate parent–child distinction, there may be a rigid boundary between the generations or so much blurring that there is little to distinguish between the roles of parents and children. The individual members may have a sense of self-awareness and be responsible for their own behavior or may evidence difficulties with self-assertion, with a poor sense of self and problems in belonging in the family. (See Figure 9-4.)

Alliances

The dimension of alliances refers to the pattern of relationships—the marital relationship, the parental relationship, and parent–child relationship(s). Parent–child interaction may be based on care and concern, appropriate attention to the children and participation in the children's activities, a strong parental coalition, agreement on child rearing, sharing of pleasure, and a mature, supportive, affectionate relationship in the marriage. We may, alternatively, find needless disagreement between parents, evident marital dissatisfaction or distance, serious discord between children, or exclusive or shifting alignment with parental conflict repeatedly being detoured through a child. The parents may be predominantly unsupportive of the children and show poor understanding of them. Parent–child relationships may be rejecting or based on exploitation, and children may be ignored or disqualified; the children may relate to their parents in a cooperative spontaneous way or one or more of the children may exhibit oppositional, withdrawn, or domineering behavior while others may avoid, reject, or cling to parents. Siblings may interact freely with shared enjoyment, affection, and concern, and differences that can be easily resolved, or they may show extreme rivalry or permanent discord. (See Figure 9-5.)

Family Adaptability and Stability

Family adaptability and stability refer to the family's capacity to function as a continuing group with commitment on the part of members. In some families, there is a lack of safety within the group and family members do not stand up to each other. There may be an imminent sense of breakup or a sense that family stability is only maintained at the cost of severe

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
RELATIONSHIP TO THE ENVIRONMENT	Family is cut off, insular, threatened, fragmented; very weak family identity.	Family is overly self-sufficient; helping agencies involved in family disturbance.	Family unit is somewhat over- or underinvolved with its social environment.	Family has a strong, distinct identity and is integrated with its social environment.
COHESION	Extreme isolation of family members, or gross overinvolvement	Members overreact to one another; or are intrusive and/or detached and uninterested.	Minimal over- or underinvolvement between members.	Family is close, but members show appropriate individuation.
INTERGENERATIONAL BOUNDARY	Overly rigid boundary or little distinction between roles of parents and children.	Parents or children disrupt generational boundaries; confusion in parent/child roles, or some role reversal.	Parent/child distinctions generally clear with occasional uncertainty or inflexibility in role behaviors.	Well-defined and appropriate parent/child distinctions.
INDIVIDUAL AUTONOMY	Members show poor sense of self, overdependence; or pseudo-independence, isolation.	Problems of separation and individuation are evident in members.	Self-assertion occurs but problems in autonomy or self-development in some areas or in a member.	Self-awareness and awareness of others; each member shows a sense of responsibility and belonging.

Figure 9-4. Descriptors from the "boundaries main scale" of the family health scales, which considers separateness and connectedness between family members and the outside world (From Kinston et al., 1987a)

and pervasive pathological interaction. The family may be overwhelmed by even minor environmental demands or it may deal with these in a constructive manner. Family organization may be flexible, with roles and relationships that adapt to meet individual needs; alternatively, it may be inflexible, rigid, or unadaptable. (See Figure 9-6.)

Family Competence

Competence deals with family conflicts, decisions, and problems. Differences between family members may need to be acknowledged and resolved using negotiation and compromise. Alternatively, conflicts remain unresolved, and there is repeated displacement, triangulation, or denial of conflict. Continuous futile arguments may develop, leading to withdrawal and the breakdown of communication. Similarly, decision-making processes may be clear and involve the appropriate family members, or they may be disruptive and ineffective and the family may not recognize the need to make decisions. Problems also may not be recognized or may be responded to in a delayed and inadequate fashion. Alternatively, the family may perceive problems accurately and tackle them with flexibility and in a spirit of mutual cooperation. Management of children is one of the key areas in which competence must be assessed. Child care may ensure appropriate behavioral control, consistency, and flexibility, or expectations of children may be inappropriate or confusing, with insufficient behavioral control. (See Figure 9-7.)

THE DERIVATION OF MEANING

Using the above concepts or dimensions, we have indicated the variety of interactional elements and episodes that can be observed when viewing the family or can be heard in reports of family life. We have already described the dis-

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
PATTERN OF RELATIONSHIPS	Serious deficiencies: marked splits, scapegoating, severe triangulation, or isolation of all family members.	Serious discord or distance between members, or shifting or exclusive alignments. Children repeatedly detour parental tension or conflicts.	Satisfactory relationships but with greater closeness or distance between some family members than others.	The nature and strength of relationships between family members is constructive and appropriate to their respective ages and roles.
MARITAL RELATIONSHIP	Destructive relationship, e.g., couple fused, at war, or isolated from one another.	Overt marital difficulties; or both partners dissatisfied.	Basically satisfactory with some areas of discontent.	Mature relationship; warm, supportive, affectionate, empathic, compatible; spouses work together well.
PARENTAL RELATIONSHIP	Parents not working together at all, or extremely weak, divisive, or conflicted relationship.	Parents repeatedly disagree, act without reference to one another, or one parent repeatedly takes over or opts out.	Basic agreement on child rearing but with some deficiencies in support and/or working together.	Strong parental coalition; agreement and cooperation in child rearing; sharing of pleasure and mutual support.
PARENT–CHILD RELATIONSHIP	Both parents reject, ignore, exploit, continuously attack, or disqualify a child.	Parental attitudes and behaviors are clearly unsupportive or harmful; poor understanding of the children.	Parents support children and enjoy being with them but with minor or occasional problems in relating to the children.	Parents show care and concern; understand and pay attention to children appropriately; and are ready to participate in their activities.
CHILD–PARENT RELATIONSHIP	Children avoid, reject, continually oppose, or cling to parent(s); or show marked differentiation in their attitudes toward each parent.	One or more children show oppositional, withdrawn, overdependent, or domineering behavior toward parent(s).	Child–parent relationships are secure, but with mild difficulties in some areas or between particular dyads.	Children relate to both parents; are cooperative yet spontaneous; feel safe and show appropriate dependence.
SIBLING RELATIONSHIPS	Sibs fight continuously or ignore each other; extreme rivalry and competition for the parents' attention.	Obvious discord or distance between the sibs.	Sibs affiliate with some limited rivalry, quarreling, or lack of contact.	Sibs interact freely with shared enjoyment, affection, concern; differences can be resolved.

Figure 9-5. Descriptors from the "alliances main scale" of the family health scales, which considers the relationships and coalitions among family members (From Kinston et al., 1987a)

tinction between the simple elements and episodes of family interaction (levels 1 and 2) and the systems of meaning and dimensions of family life (levels 3 and 4). We must now turn our attention to the way in which we make sense of the particular interactions. An understanding of meaning is required to make the connections that enable us to create a total picture of how a given family works at present (level 5).

We have indicated that meaning is derived from a context-based interpretation of observable interaction. The aim is to provide an account

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
FAMILY STABILITY	Sense of imminent family breakup; stability is only maintained at the cost of severely dysfunctional interaction.	Feeling of insecurity within the family; lack of commitment to the family.	Family has a secure identity, but some evidence of fragility or instability.	Family is secure as a continuing group with high commitment from its members.
RESPONSE TO CHALLENGE	Family ignores or is overwhelmed by demands or its own needs; relates poorly or destructively to its environment.	Family relates to environmental demands or needs of members in a paranoid, confused, or stereotyped way.	Family responds fairly well to problems and challenges but with some inconsistencies or difficulties.	Family deals with internal and external demands constructively; and takes opportunities to develop itself.
ORGANIZATIONAL ADAPTABILITY	Family is so rigid or so chaotic that severe disruption and minimal adaptation follow stress.	Roles and arrangements are inflexible and often inappropriate to family needs or to particular circumstances.	Family organization is flexible, but with blocks or rigidity in some areas.	The family is able to adapt rapidly and appropriately to meet individual needs and changing circumstances.

Figure 9-6. Descriptors from the "adaptability and stability main scale" of the family health scales, which considers the capacity to alter to meet changing needs and circumstances while remaining the same (From Kinston et al., 1987a)

that can be said to make sense of the interaction, which is the object of study. Such an approach is usually described as a hermeneutic one, and it is an essential part of the needed psychoanalytic tradition (Ricoeur, 1970), and, some would say, of all social science (Steele, 1979). Interpretations or systems of meaning can be seen as the depth structure of a family in contrast to interactions, which are surface manifestations. Meanings structure confusion and obscurity and are validated by a community of like-minded interpreters. Interpretations, therefore, can be used as a basis for deductions and nonclinical investigative efforts (e.g., Kinston et al., 1987a, 1987b, 1988a, 1988b). In other words, we are putting forward a view that family interaction occurs within a coherent meaning field, a view that, broadly speaking, family therapists share.

To be a human being is to experience one's situation in terms of meaning, and family interactions that occur against a background of desire, feelings, and expectations are inevitably charged with meaning. *There is no one-to-one correspondence between surface action and depth meaning.* A particular interaction pattern may relate to a variety of different meanings, and a particular meaning (and its associated actions) constitute a family reality. We have found it helpful to distinguish between common meanings and intersubjective meanings.

Common Meanings

Common meanings are rooted in the psychic life of the individual family members. Each member has his or her own unique experience, much of which remains unconscious or private and not directly relevant to the concerns of other family members or the family therapist. There are certain common meanings that, however, are shared at the time of marriage and develop in common afterwards. When children appear, they assimilate and contribute to these. Common meanings are exchanged and shared, unconsciously and by example and instruction, and include beliefs, views, guiding principles, fears, and expectations. They are the basis for belonging, loyalty, and cohesion within the family. Common meanings are essential for comfortable communication, pleasurable participation in interests, and tolerance of each other's pain. They

	Breakdown	*Dysfunctional*	*Adequate*	*Optimal*
CONFLICT RESOLUTION	Conflicts are denied or ignored, lead to continuous futile arguments, or to withdrawal and breakdown of communication.	Poorly handled conflicts disrupt completion of tasks. Members become embroiled in the conflicts of others.	Conflicts generally acknowledged and resolved, but occasional overreaction, denial, or lack of resolution.	Conflicts acknowledged and resolved by negotiation and compromise between the relevant participants.
DECISION MAKING	Decision making is severely impaired: no recognition of need for decisions; lack of acceptance of result; no action on decisions.	Making decisions is a problem for the family. The process is often disrupted or ineffective.	Decisions are generally taken and acted upon where necessary, but with occasional difficulties or dissatisfaction.	Decision processes are clear, involve members appropriately, produce satisfaction, and outcomes are accepted.
PROBLEM SOLVING	Lack of capacity for solving problems in an effective way.	Problems often not recognized, or response is delayed, inadequate, uncoordinated, or impulsive.	Problems are tackled but somewhat inflexibly, inefficiently, or simplistically.	Problems accurately perceived, tackled with flexibility and good sense; spirit of cooperation.
CHILD MANAGEMENT	Behavioral control is absent, chaotic, bizarre, or ruthless.	Overt problems managing children; unrealistic or inconsistent expectations.	Children handled fairly well, but some difficulties or inappropriate expectations.	Expectations of the children are realistic and control is flexible yet consistent.

Figure 9-7. Descriptors from the "family competence main scale" of the family health scales, which considers the skills required to carry out the family tasks of nurturance and socialization (From Kinston et al., 1987a)

are the basis of consensus, easy conflict resolution, and a coherent response by the family to the environment and to developmental changes. When a member leaves the family, he or she can take these meanings without disrupting the family and can use them in the creation of a new family.

Intersubjective Meanings

Intersubjective meanings, by contrast, are not the property of any single member, but instead are rooted in the interactions that constitute family life. They are, therefore, part of the self-definition of the family as a whole. Intersubjective meanings are created by different members taking up complementary roles. Should a member leave, he or she can only perpetuate the meaning by finding others who relate in a particular way or coercing them to do so.

In a psychoanalytic theory, complementarity is understood by use of object relations theory. An individual is described as projecting an aspect of himself or herself or interjecting aspects of others. Such activities result in the individuals involved being locked together. If one departs, a substitute must be found.

Powerful common meanings lead to the development of a web of intersubjective meanings. This notion is not a new one in family theory and has been referred to by a number of labels, including "family matrix," "family identity," and "family myth." These terms clearly express the notion that the family has its own reality, which members serve. It has been noted that members of healthy families appear weaker when seen separately at interviews, whereas in poorly functioning families, a separate individual interview reveals strength in members (Lewis et al., 1976). This is so because the family's emotional and cultural reality has an obscuring effect on its members' psychic reality.

Stress and the Development of Dysfunction

We have already commented on past traumatic events as a critical factor in the presentation of a family for therapy. The experience of an event as stressful and potentially traumatic depends on existing meaning systems based on urges for survival, well-being, and attachment. Meaning systems are required for the psychological handling of stress and the activation of any frequent, and possibly continuous, experiences that are mainly unconscious. Systems of meaning developed during childhood ordinarily can subsequently undergo relatively minor modifications, but there may be major alterations in adults following massive trauma (Kinston & Rosser, 1974). Psychoanalysis aims at a major revision of meaning.

In family therapy, we refer to the parents and children who present for help as the "family of procreation" and the previous generation (that is, grandparents, parents, and siblings of parents) as the two "families of origin." In the families of origin, the parents obtained personal experiences and family life experiences that resulted in unique systems of meaning. Marital choice then depends on both similarities (common meanings) and complementarity (intersubjective meanings). Children are born into this marital reality and immediately alter it. Events that occur in the family of procreation have minimal adverse effects on the children if the parents can contain their mental impact and can connect them positively. Children usually cannot be completely shielded from traumatic events, as most are unconsciously produced by the parent. However, parents and others can assist in repairing the damage. The health-promoting processes of acceptance, integration, and resolution and working through of meanings associated with traumatic events are often incomplete in childhood and are the basis of vulnerability to stress in adulthood.

Healthy families adequately nurture and socialize their children and provide psychosocial protection and support for all members. Functioning in the main dimensions may not be optimal but is adequate. Underlying and enabling this is a functional web of common and intersubjective meanings. Dysfunctional families that show inadequacies on the main dimensions reveal certain characteristics in their episodes of interaction, which need to be noted in a clinical assessment. The characteristics are as follows:

1. *Repetition.* Certain interactions are extremely repetitive, often to the point of characterizing the family.
2. *Irrelevance.* Pathological interaction appears to be independent of external events and irrelevant to the needs of the situation. Cycles of interaction often appear to be set off randomly or haphazardly.
3. *Vicious circles.* Dysfunctional patterns of interaction exist that are self-maintaining.[4] Each element leads to the next and finally back to itself (hence we refer to the episodes as "cycles.")
4. *Compulsiveness.* A simple request to the family to stop behaving in this way cannot be complied with for any significant length of time, and often not at all.
5. *Urgency.* The cycle has a dominating and urgent quality that overrides apparently destructive consequences.
6. *The symptom (or presenting problem) is part of the cycle.*

Looking at cycles in terms of common and intersubjective meanings reveals clinically important differences among families. For instance, pathological common meanings may predominate or constructive meanings may be lacking, or intersubjective meanings may excessively influence the role assigned to a particular family member. The following example illustrates these points.

In Kinston and Bentovim (1981), we described the K. family, an enmeshed family in which common meanings were pathological. Thirteen-year-old Sheila presented medically with life-threatening obesity and was admitted for rapid weight loss and psychological management. Family members believed in the importance of mothering in the family to the degree that all members expected the mother's complete availability. If the mother was absent, the father took

[4] *Editors' Note.* Of course, functional patterns of interaction exist that are self-maintaining in healthy families. It is not the circularity of causality that distinguishes health from pathology, but our labeling of given patterns as desirable or otherwise.

her place and followed the same rules, which included the prescription that family members should speak whenever they wanted, members should ignore any other family member's discourse, and members should eat whenever they wanted. The meaning of these rules, which were held by each individual as well as being part of the family culture, was that "separation or any threat of separation is equivalent to total abandonment and death." This meaning was associated with complete avoidance of the awareness that severe obesity was itself life-threatening.

In another family described in the same chapter, there was absolute disagreement as to whether or not the family would have another child. It emerged that there was a lack of common meanings where they were required. The first child had been adopted and the second child was born with a variety of physical abnormalities. The father, in his family of origin, had a sibling born with severe mental retardation, and following the birth of his own child with minor physical problems, he felt he could not take the risk of a further child being born impaired. He was convinced the child would be severely handicapped like his sibling. The mother, on the other hand, experienced her own upbringing as one occurring in a state of blissful warmth and care, due to the attention paid to her minor asthmatic problem. For her, a further child represented a welcome addition to the family and she felt no concern about a possible handicap. Indeed, for her, a degree of handicap was an additional welcoming feature. A lack of common meanings with respect to another child thus led to interpersonal distance and a failure in conflict resolution.

As an example of pathological intersubjective meanings, we described a family where a father and his young adult son constantly quarreled and competed, activating each other into dangerous and risky behavior, such as driving recklessly while drinking and taking drugs. The mother found herself shifting in her alliances, supporting her husband and her son in turn. This repetitive pattern of interaction acquired meaning in the context of the family's histories. Both parents had fathers in special roles, yet these roles were diametrically opposed. The father's father had died early and was greatly idealized by his mother. The mother's father had left the family at an early age and was as greatly denigrated. Both parents had never mourned their own fathers, but instead preserved them intact in the family despite their totally opposite characters. The relationships with dead fathers were involved in the intersubjective reality of the current life. On the one hand, the father found himself having impossibly ideal expectations for his own son, much as he had felt from his own father, and this led to merciless criticism. At the next moment, the father found himself criticized and denigrated by his wife when she offered maternal support to her son. Thus, a classical triangling situation based on complementary roles expressed powerfully held intersubjective meanings concerning father–child relationships.

When families are in the grip of such intensely held meanings, they cannot respond effectively to actual current events and experiences. Meeting the stresses of family life and fostering the development of individuals require a variety of flexible responses. But overpreoccupation with intense fears and historical concerns led, in the examples given, to such actions as overeating, conflict between parents, and dangerous life-threatening activities, which are, in effect, avoidance maneuvers. Such avoidance maneuvers may be deployed to prevent a family from facing any aspect of the whole gamut of human experiences, whether this be mutuality, commitment, intimacy, loss, separation, individuation, personal change, disappointments, or even historical reality. Pathological cycles of surface action with their dominating urgent quality result in the emotional implications of many different aspects of life being ignored.

A Proposed Typology

Level 6 refers to a classification of families. Any classification depends on the form of lower-level description. We have proposed, but not yet validated, a typology that emerges from our descriptive approach.

In the families that come to our clinic, it is possible to distinguish those where the primary stress that gave rise to pathological meanings and dysfunctional cycles occurred in the family of origin from those where attendance is due to stressful events in the family of procreation. In other cases, the presentation implies severe stresses in both the family of origin and the fam-

ily of procreation, either because events in the previous generation had so affected matters that stresses in the family of procreation are precipitated, or because family-of-procreation events have activated buried, but not inactive, family-of-origin traumas.

We have distinguished the following three mechanisms for the handling of meaningfulness. These explain the formal characteristics of the operative meaning system in the family. The mechanisms apply to events in either the family of origin or the family of procreation, although with the final result differing in each.

1. *Denial, nonassimilation, or ignoring.* For example, the obese family showed a complete lack of appreciation of the life-threatening nature of obesity.
2. *Repetition without resolution or working through.* For example, in the family with father–son quarrels, there was a straightforward re-creation of attitudes toward fathers.
3. *Depositing or reversal,* that is to say, attempts by a family to turn experiences into their opposites. For example, parents who lived in foster care themselves as children may become absolutely determined that, whatever the consequences, their child will not go into foster care.

Although these mechanisms are not independent of each other, they do seem to be applicable independently and to make sense when applied clinically. Byng-Hall (1989), for example, describes replicative and corrective scripts in families corresponding to types 2 and 3 above. We suspect that particular characteristics and forms of family interaction in the presenting family (that is, the family of procreation) can be linked with each of the categories in Figure 9-8, which summarizes our clinical findings. If there is no trauma, this means that stressful events have been accepted and worked through to form functional, common, and intersubjective meanings (category A). Categories B and C indicate the differential effects on meaning, depending on whether the site of stress is the family of origin or at procreation and according to the mechanism used for handing meaningfulness. Category D refers to those families where stress is to be found in both generations. We are currently studying this classification using our key method of description, the focal formulation and focal hypothesis, and it is to this that we now turn.

THE HOLISTIC FORMULATION

A holistic view of the family has been built into our approach by requiring the therapist to develop a focal hypothesis to explain *all* known disturbances in light of the family history. To assist the therapist in gathering and laying out the information required for creating a focal hypothesis in a systematic way, we have developed a focal sheet (its details and a case example will be provided later). Its essence is captured in a focal hypothesis. There are four logical steps in the construction of a focal hypothesis, or holistic formulation.

Step 1. How Is the Symptom a Part of the Interaction?

The first step in making a focal hypothesis is to restate the symptoms in family interactional form or as an expression of a family meaning. In other words, it is necessary to clarify the features of the symptom or problem presented and appreciate how it fits into the family (or sometimes into the family-and-agency context). That is, we ask ourselves, "How does the family interact around the symptom, and how does the family interaction affect the symptom?"

Example 1 (from Kinston & Bentovim, 1982) is the difficult L. family with Richard, a 6-year-old boy with behavior difficulties. He was unresponsive and defiant and had frequent temper tantrums. These problems, combined with his lack of friends and his poor school progress, were recognized as getting him excluded from the family, drawing his parents together.

Example 2 (from Furniss, Bentovim, & Kinston, 1984) is the J. family, which was referred for help with Nikos, a 10-year-old, mentally handicapped boy. He was well adjusted in his present school, but disinhibited, hyperactive, and uncontrollably aggressive in the family. The symptoms were especially prominent in public and with his father. The symptom in the family context was found to be an expression of the

Site of Stressful Events	*Handling of Meaningfulness of Events by Family Members Involved*	*Characteristic of Operative Meaning System in Presenting Family*
A. Family of origin and family of procreation	Accepted, integrated, resolved, worked through	Functional web of common and intersubjective meanings
B. Family of origin: • Events that have affected both parents as children and hence their ways of being and systems of meaning	Denied, ignored, not assimilated	No meaning, loss of meaning, artificial meaning
	Repeated, accepted, not resolved, not worked through	Shared pathological common meanings and repetition of intersubjective meaning
	Deposited, reversed	Reversal of past intersubjective meanings
C. Family of procreation: • Events that affect the mother and father as adults and require integration within already operating systems of meaning	Denied, ignored, not assimilated	Displacement of meaning, falsity of meaning
	Repeated, recreated	Lack of shared common meaning
	Deposited, reversed	Shared common meaning that x is bad or contains all bad things
• Events, including the parental response, that affect the next generation • Or current (e.g., handicap, accident, stage in family life cycle)		
D. Family of origin and family of procreation: • Events in the former, including the resulting systems of meaning that lead to events in the latter • Events in the latter that activate undealt-with issues in the former	(Combinations from the above)	

Figure 9-8. Classification of family pathology.

family belief (meaning) that nobody should control any child.

Example 3 (from Jacobs, 1986) is the D. family, consisting of two parents and four young adults. This was an unusual situation where the only daughter, who was 21, was involved in an ongoing incestuous relationship with her father. We concluded that the symptom was not the incest per se but its public announcement. Drawing the rest of the family's and professionals' attention to the ongoing incest kept the family together, and, in particular, increased parental concern and marital closeness despite the discomfort.

Example 4 is the Q. family, an Orthodox Jewish family in which the 16-year-old daughter presented with weight loss, cessation of periods, and school failure. The therapist concluded that

her attitude toward these problems focused parental attention on her exclusively, and meant that other children in the family were ignored.

Step 2. What Is the Function of the Current Interaction?

Having established the way that the symptom is a part of family life, the next step is to determine the function of the symptom-interaction complex. The therapist has to infer from a variety of clues what the current interaction (in which the symptom is embedded) would be were it not present.[5]

In the L. family, we suspected that if the parents did not draw together and exclude their son, the result would be severe conflict between the parents.

In the J. family, with the uncontrollable handicapped child, we concluded that taking control of the children would mean viewing Nikos as handicapped rather than as naughty.

In the D. family, containing an incestuous relationship, we concluded that the incest controlled emotional closeness between the parents: too much might lead to actual physical violence between them, and too little, or complete marital separation, would result in the father's becoming overtly psychiatrically ill.

In the Q. family, with the failing elder daughter with anorexia nervosa, we concluded that removal of attention would make the family face problems in the other children—the 13-year-old son with early autistic symptoms and the 9-year-old son who was also failing markedly at school.

Step 3. What Is the Disaster Feared by the Family?

The third step is to ask what the disaster is that is so feared by the family that the interactional consequences clarified in step 2 cannot be faced and dealt with sensibly. Why, for instance, in the L. family is marital conflict avoided? Why in the J. family is recognition of the child's handicap avoided? Why in the D. family are the acceptance and handling of marital violence or psychiatric illness avoided? Why in the Q. family are the sons not being helped?

In the L. family, the feared disaster was that marital conflict would inevitably lead to marital breakdown. In the J. family, recognizing the handicap would mean taking the blame for it. In the D. family, there was a conviction that violence would lead to murder and psychiatric illness would lead to suicide. In the Q. family, there existed a fear that if the daughter were not the center of the mother's life, she (the daughter) in effect would be abandoned, and an intolerable recognition of the boy's chronic autistic handicap would be forced on them.

Step 4. How Is the Current Situation Linked to Past Trauma?

It could be argued that anxieties such as those listed are present in many families and that their selection is arbitrary and nonspecific. However, following our theoretical principles, a fourth step is essential. A plausible link between formulations developed in the previous steps and salient traumatic events in the past family life must be demonstrated using available evidence and psychodynamic principles.

In the L. family, we speculated that the most salient historical event was the mother's incestuous relationship with her own father, the discovery of which eventually led to his imprisonment and to marital breakdown. The link between this family-of-origin trauma and the current family dysfunction appeared to be that if parental relationships with children compete with the marital relationship, the end result will be the breakdown of the marriage. Only complete exclusion of the child can prevent this. This is the reverse of the exclusion of the parent as occurred in the family of origin.

In the J. family, what appeared most salient was that at the time of the mother's pregnancy with Nikos, there was a period of intense marital conflict and the therapist discovered that a con-

[5] *Editors' Note.* We believe it is essential that the therapist not overlook the distinction between the *function* of symptoms and interactions and the *consequences* thereof. Consequences require systematic descriptive *observation* to be determined, while functions require systematic *inference and attribution* to be arrived at.

viction had developed that this conflict had actually caused the handicap. Facing the handicap now would mean facing this guilty knowledge. The trauma here lay in the family of procreation.

In the D. family, the prime salient events were identified in the father's family of origin. The father had been beaten as a child, which was justified by moral strictures, and his brother had attempted suicide after being abandoned by a girlfriend. These traumatic experiences provided the conviction that violent action is possible and permissible and that death follows abandonment or separation. Each of the parents had an isolated young adulthood and each clung to the other. This clinging led to an inability to deal with conflicts and to sexual failure. Incest maintained the parents' marital relationship, but at a safe distance.

In the Q. family, the salient trauma lay in the mother's family of origin. The mother was a Holocaust survivor. Her own mother, the maternal grandmother, was her only surviving relative, and they clung together. The maternal grandmother had to support the family and so could give only limited attention to her daughter, who felt abandoned. Also salient in the history of the father of the family was a younger brother who had been hospitalized with a psychotic illness, and the father himself had had a psychiatric illness when he was in his 20s. Thus, the context was established for feared recreations of environmental disaster, chronic psychiatric illness, absence and weakness of fathers, and mothers and daughters distant from each other.

Step 5. Summarizing the Focal Hypothesis

It is necessary to summarize the focal hypothesis to produce a short memorable statement, which the therapist can keep in his or her mind in working with the family.

First case: "The L. family is excluding the child so as to overcome a marital breakup as occurred in the family of origin due to a competing parent–child relationship."

Second case: "The person who takes control of Nikos turns him from a naughty boy into a handicapped boy, and so has to take responsibility and blame for the handicap, which the J. family believes was caused by marital conflict at the time of the mother's pregnancy with him."

Third case: "Incest between the father and his young adult daughter keeps the parents and other members of the D. family together, but at a safe distance apart because closeness would lead to violence and possibly murder, while separation would cause worsening of psychiatric illness and suicide, based on what occurred in the family of origin."

Fourth case: "Rachel's symptoms focus parental attention on her, thus helping them to avoid repeating a family situation, where a daughter is abandoned. In addition, it diverts them from the major handicaps of their sons because such damage is intolerable given the past disasters in both parents' lives."

Requisite Changes

Having developed a holistic integration of the relevant aspects of family life, we can now turn to level 7, an ideal potential scenario of what the family could be like. This is what is requisite for the family. It is necessary for the therapist to specify required changes that would be meaningful for the family and possibly achievable through the therapist's own work. Requisite changes can be specified before the institution of therapy and can be used by "blind" assessors at follow-up. As well as these system changes, symptomatic alteration is always required. On its own, symptom loss is insufficient. We noted in our earliest paper (Kinston & Bentovim, 1978) that symptomatic change alone may be a "false" indicator—for example, the disturbance may move from one child to the other, or to the marriage.

Requisite family-system changes should specify actual alterations in interaction and not depend on vague or abstract notions. While criteria do need to be essentially objective (that is to say, socially sharable events), they must not be based on excessively subtle shades of intuition. Hence, carefully specified criteria can lead to stringent and convincing evidence of therapeutic effect. Still, it may be difficult to decide whether the change in interaction following therapy actually meets the criteria for successful outcome. It is not always possible to give explicit details of targets for change because of

the open-system nature of the family. A variety of forms of surface interaction may contain and express the therapeutically achieved resolution.[6] Changes in meanings are recognized by alterations in interaction or expressed beliefs or in the ability of the family to discuss previously unmentionable subjects.

Since there are many ways to achieve a desirable outcome, the criteria themselves (though not the way they are decided) need to be concrete and independent of the modality of treatment or the theoretical stance. For example, references to "ego strength" or "absence of double binds" are not satisfactory.[7] The family itself may initially not be aware of or not value some material, unlike the symptom or conventional goal-attainment scales or change targets. For example, acknowledgment of the traumatic experience judged to be the origin of the disturbance is not meaningful to most families at the onset of treatment. We will discuss a case later in detail to demonstrate the therapy process, but in the four cases we have already mentioned, descriptions of the requisite level were as follows:

1. In an improved L. family, the parents would speak directly and openly to each other and face up to and resolve their conflicts. Richard would be perceived reasonably accurately as both good and bad and would not be triangulated into the parental relationship. Richard's behavior would improve so that he would invite rejection less often. The 4-year-old boy in the family would be described and related to by the parents realistically and not treated as special and ideal. Richard and John would relate more closely in an age-appropriate fashion.
2. In the improved J. family, the parents would take control over the children. Nikos would not be allowed to be destructive and would stop swearing, and the provocative and difficult behavior of the other children would also be dealt with firmly. Appropriate generational boundaries would be established; for example, the parents would be able to talk to each other without a child's stopping them. Each parent would acknowledge achievements of the other and would not undermine the other. The parents would be able to talk about their feelings of responsibility for the handicap, and would cease seeing Nikos as the "bad one." Nikos' potential and degree of handicap would be realistically acknowledged.
3. In the improved D. family, a decision would be taken to stop the incestuous relationship. The parents either would decide to separate or would find a way of living together harmoniously. Mental health issues would not predominate in family discussions. All the adult children would move off to create their own lives and families in an independent way.
4. In the improved Q. family, the oldest daughter's periods would return and uncertainty about her weight would stop. The oldest daughter would also be less jealous and undermining. The parents would let her pursue her own career and would cease being overconcerned. The parents would be able to talk together about their handicapped son. All family members would stop interrupting and talking for each other. The younger son would work up to his potential.

ASSESSMENT FOR THERAPY

In the previous section, we described how we conceptualize the problem presented by the family or by the referring agency. We have also described the way in which we form a focal hypothesis and decide what would be requisite for a family in terms of a possible useful outcome of therapy. We now need to turn to the practical task of assessment so that we can describe in some detail how this goal is reached. From the

[6] *Editors' Note.* Of course, for research purposes, one would, nonetheless, need to offer rules regarding how one would decide what types of change constituted "resolution," lest all manner of "evidence" qualify as supporting the efficacy of a particular method of treatment.

[7] *Editors' Note.* We disagree with this assertion. While, for example, vague references to "ego strength" are inadequate as outcome criteria ("required formulation"), there is real value in assessing the effectiveness of a given therapeutic method in terms that are theoretically specific to, and meaningful within, that way of thinking. Whether a particular method *also* yields significant clinical changes that are outside or beyond the tenets of that way of thinking is a very important, but very different, matter.

earlier sections, it can be seen that developinga holistic formulation requires appreciation of many factors: cycles of dysfunctional interaction, stressful events and experiences in families of origin and during the life of the current family, meanings and themes that were prominent, and the quality of family life on various quasi-holistic dimensions. We need to be able to gain information in all of these areas as part of the assessment, and we do this principally through a family diagnostic interview.

The Family Diagnostic Interview

Conceptually, we separate the assessment process from treatment, but in practice, effective work with a family demands that the therapist join therapeutically with the family from the very beginning. The initial contact with a referred family usually involves tasks, such as contact with the referrer, convening the initial meeting, and conducting the interview, all of which need attention if the assessment process is to be carried through properly. As far as the family is concerned, contact should be experienced as therapeutic from the very outset and not merely as a routine event prior to going on a waiting list. In the initial one or two sessions, the therapist needs to answer the question of what the family is about and be clear that simple responses, such as referral to a remedial teacher or a basic medical diagnosis or advice on handling crises, are not all that is appropriate. Generally speaking, we favor inviting the whole family from the outset. In addition, professionals who play a major role in family life are invited—for example, social workers from a welfare agency, a probation officer appointed by a court, or a community nurse involved in ongoing health care. In the hospital setting, the pediatric specialist would also participate. Subsequent individual marital interviewing may be required for the assessment. Contact with other professionals in the network, such as the family physician, may also be indicated.[8]

The interviewing method varies greatly depending on the orientation and style of the therapist. Like most pragmatic research, the issue is not what questions are being asked, but whether enough questions are being asked to provide the information the interviewer needs in order to carry out the assessment that we have indicated is needed.

We have found it helpful to use a number of techniques, including circular questioning, triadic questioning, the "gossiping" technique, structural techniques, and communication tasks (e.g., the "discuss this among yourselves" tactic). There may be times when specific tests are necessary, as in the individual assessment of the intellect of a child or parent. When family disturbance appears to be absent, it may be helpful to use a family task interview. Our research with this interview confirms that the therapist's presence and participation obscure the very interaction he or she needs to identify (Stratford, Burck, & Kinston, 1982). Instead of carrying out the whole interview, one or two of the formal tasks may be carried out by a family with or without the therapist present, such as planning an outing, building a tower of bricks, discussing how family names were derived, or discussing likes and dislikes of members. There are also a number of more clinically oriented tasks, including asking a family to construct a genogram together while the therapist observes them via closed-circuit television or a one-way screen. Tasks like this give the family a simple and relatively unstressful experience within the assessment process and may assist the therapist in joining with them.

When referrals are made from other agencies, there may be legal requirements to be handled. For example, in our work with sexually abused or physically abused children, it is often useful to ask the family to discuss with the social worker the reasons for referral during the diagnostic interview. This task can help reveal the interactional process between the family and the care environment.

Although our approach is pathology oriented, the formulation of requisite change demands that the therapist appreciate family strengths. The approach of the family to tasks given during the therapy provides an indication of the re-

[8] *Editors' Note.* See Imber-Black's (Chapter 19) discussion of a systematic approach to dealing with clinical issues of the family's relationship to larger social systems, especially to systems of professional helpers.

sources of the family, as well as dysfunctional patterns.

The Focal (Family) Therapy Assessment Sheet

To gather the mass of information that can arise from a meeting with the family, and then to derive a focal hypothesis and a statement of the requisite change, we have found it essential to have a format we call the Focal (Family) Therapy Assessment Sheet. It consists of a front sheet to record actual key details and a number of columns to record various aspects of the family context, complaints, and family description.

Front Sheet

The front sheet is used to record key factual details that set the scheme for the assessment interview(s): the name of the family, the referral agent, and the date of the interview. A family tree bringing in as much of the extended family as is relevant can also be inserted here (see Figure 9-9).

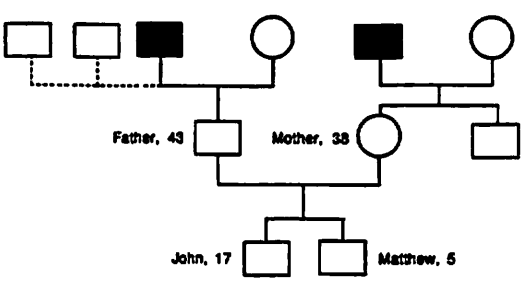

Figure 9-9.

Column I—Family Composition and Professional Network

The first column contains facts about the family and its members, including their names, ages, family status (e.g., step-relative, foster or adoptive child), country of origin, and occupation or school. Names are noted in age order spaced out down the column and that of the index patient is underlined or asterisked. All family members and active members of the household, such as lodgers, are included. The permanent absence of family members from interviews is noted. In the lower part of the column, members of the professional (e.g., general practitioner, social worker) and paraprofessional (e.g., priest, helpful neighbor) network who are involved with the family are noted.

Column II—Current Complaint

Information about the complaints that have brought the family to treatment is recorded in this column. Details of the onset, nature, and duration of the complaints are inserted adjacent to the name of the relevant family members, using their own words. The definition of the current complaint as presented by the referrers and others in the helping network is recorded in the lower part of the column, if this differs from that of the family.

Column III—Reported Past Events, States, and Relationships in Previous and Current Family Systems

This column contains past events, states, and relationships chosen because they are considered to be salient or significant to the family as traumas or stresses that are likely to have had sufficient impact in shaping family life. Some events that the therapist feels still have a bearing on present-day family life may not be seen as relevant by the family. Clinical judgment is used, therefore, in deciding salience. The events are recorded in chronological order, approximately in line with the family member(s) to which they refer.

It is necessary to distinguish between events in previous family systems (i.e., the families of origin or other families in which the family members have been involved, such as previous marriages) from events in the current family system.

Column IV—Surface Action

This column allows recording of both reported and observed overt interactions. Reported material about current family life and relationships may be obtained from the family itself or from outsiders. The observed surface action refers to dysfunctional cycles within the family, including family–therapist interactions, which are judged to be characteristic. It is best to adhere to the present tense here and it may be useful to include a structural map of the family.

Column V—Meanings Active in the Family

Meanings, beliefs, or values that are active and alive consciously and unconsciously in the family, and that underlie and drive surface action, are detailed in this column. It should be possible to illustrate the meanings by reference to interaction and to statements from family members. Meanings should be identified in a short, pithy form highly specific to the family concerned.

Column VI—Handling of Stressful Events

In this column, the information in columns III, IV and V must be linked. The therapist records his or her speculation about the way in which the family has handled the key stressful events and which meanings have been attached to them. In other words, the therapist develops a theory of how past experiences have become part of the family's characteristic culture and behavior in the present time.

Column VII—Requisite Changes

This final column contains the changes in the family that the therapist decides have to take place if the therapy is to be considered successful. These changes are delineated in concrete, behavioral, and visible terms as far as possible. All dysfunctional meanings in column V should have been resolved by the end of therapy, and the family should be able to talk about them. The salient traumas should also be open to acknowledgment and free discussion by the family. Changes may need either to be observed by the therapist or, in some matters, to be reported by the family.

Using the Assessment Sheet

Making a focal assessment, creating a focal hypothesis, and determining requisite change require the therapist to stand back from the family and take a comprehensive and holistic view of it. It is, therefore, positively undesirable to attempt to use the Focal Therapy Assessment Sheet as a recording tool during a diagnostic interview.

We have developed an individual and a team approach to deal with the complexity of assessment. If a team is used, members of the team should divide up the various recording tasks; for example, one member of the team can note cycles of interaction while another listens for the salient events and the meanings of these for the family and a third gathers the factual information. It is also usually helpful to have one team member keep a running process record of the interview as a whole. In addition, a video recording of the family session may be useful to check the information that the group has derived. The sheet can then be completed by the team as a whole during a break or as an entirely separate operation on a later occasion. The therapist's work with the family involves the therapist in observing the family, acting or intervening in various ways, and evaluating his or her own responses as well as those of the family. This normally is an implicit process but for training purposes it can be done explicitly. What is required is a level 1 description of interaction from the videotape, in which all significant elements, comments, actions, and expressions are noted and divided into natural level 2 segments or episodes. The therapist then has to make a level 3 description, that is, must attribute meanings to the interactions observed. All this needs to be done in the light of the therapeutic purpose, which is to derive a focal hypothesis.

To illustrate this process, a part of the initial assessment of the G. family[9] containing two boys—John, aged 17, and Matthew, aged 5—is provided in Table 9-1. Matthew was referred at the age of 5 years by a pediatrician because of his worsening overweight, disruptive high levels of activity, and aggressive behavior, particularly at school. On the left-hand side of Table 9-1 is a description of what was happening in the interview based on a videotape recording, and on the right-hand side are the comments of the therapist about her aims, in response to attempts by a supervision group to clarify and specify the meaning of the interaction. The final focal formulation and focal hypothesis that were derived from this particular case are shown in Figures 9-10 and 9-11.

THE THERAPY PROCESS

The major goal of therapeutic work is the resolution of the trauma embedded in the family and captured by the focal hypothesis. This applies to every family. Trauma has a damaging effect on the relationships and the feelings and behaviors of family members and it is these with which the requisite changes are concerned. What in other therapy models would be seen as goals of treatment (e.g., a parent taking control of a child's behavioral difficulties) in our approach is an expected by-product of the resolution of the traumatic issues that spill over into all aspects of the family's life. This goal, articulated to suit the particular family, needs to be shared with the family at some suitable point in the therapy. Some families may grasp the issues very quickly whereas with others this awareness occurs far later in the process. The language of the focal hypothesis is simple and rooted in family life, so the level of comprehension or thinking within the family is not an issue. We do expect to have our hypothesis of the family dysfunction discussed explicitly at some point in the therapeutic work, and we also expect the results of effective therapy to be seen in individuals as well as in the family as a whole.

The Mechanism of Change

We have emphasized that in our approach we regard cure as dependent on the resolution of trauma, which is recognized by the family's developing a number of prespecified requisite changes. To achieve this goal, it is appropriate to employ any technique at the appropriate tactical and strategic junctures in the therapy, using the guidance of the focal hypothesis (or systems model). Although all family therapists are concerned with interaction, our hierarchy of description points to a contrast between those therapeutic approaches that center primarily on a particular problem or mode of interaction of the family and those that aim primarily to restructure patterns of relationships within the family (i.e., regard the family as a whole as the object of assessment and change). Although our approach belongs unequivocally to the latter group, families are frequently more than content with limited change. The distinction between narrow and broad aims for change is a source of conflict among different family-therapy schools and produces confusion in outcome studies.

The broad approach demands a breakdown of existing patterns and the reconstruction of a different family culture, identity, or theme. Restructuring must be stable and should assist the family and its members to evolve in a constructive fashion after therapy. The more a therapeutic approach is oriented toward restructuring, the greater will be the need to take a historic–genetic approach and so provide interventions that contribute to the creation of a new psychological reality. The approach developed by Chasin (Chasin, Roth, & Bagrad, 1989) is naturally incorporated as describing techniques of creating new future and past realities. Where a more limited goal for change is accepted, interpretation or reframing can be used, but it is provided pragmatically or opportunistically to impart impetus. In holistic change, the therapist's personality and psychological health may also play an important part. Intense feelings and thoughts in the therapist–family relationship—that is, transference and countertransference—are then more likely to develop.

[9] We wish to thank Anne Elton, principal psychiatric social worker at the Hospital for Sick Children, Great Ormond Street, London, for permission to use this case and for her detailed assistance in preparing the material for publication.

TABLE 9-1.
Detailed Analysis of an Initial Assessment of the G. Family

In the early part of the session, the therapist "joined with" the family—the parents, and sons John, 17, and Matthew, aged 5. In observing the problem the parents had in controlling Matthew's noisy, disruptive behavior, she established the parents " 'fear of violence' and 'loss,' " and their difficulties in establishing control of him. She joined with John, the adolescent in the family, and brought both parents into the session. Shared areas of dislike were clarified (e.g., of "work" for all family members) and their personal concerns and difficulties were determed (e.g., John's obesity at the same age as Matthew). Previous marital problems were identified.

Account of Interview—Section of First Interview	*Comments of the Therapist*
1. Therapist now asks why the famly is here and what the biggest worry is. John thinks the reason is that his mother is especially worried about Matthew being very active but then adds that she is worried about both he and Matthew fighting. The mother says these two things are linked and goes on to describe how worried she is that Matthew does not know his own strength and might really damage a small child in a fight. Meanwhile Matthew, sitting beside the mother, is carolling and singing away in a totally nonchalant and somewhat contemptuous manner, indicating his total lack of concern for his mother's anxiety.	1. The therapist wanted to discover what problems, experiences, and concerns there were. She concluded that the family was greedy, confused, and overwhelmed by a host of difficulties and could not focus on the most important problems. It was noted that the family members were undermining each other, talking across each other. Matthew's behavior was totally ignored.
2. The mother thinks that the father worries about Matthew. This is said in a rather meaningful way, with the emphasis on "worries." She adds that she thinks the father may also worry about Matthew's effect on her and her way of coping with him, which has not been very successful, especially when he is more active and potentially dangerous. In her description of Matthew's behavior, she shows a mixture of some admiration at his cleverness and exasperation at his demands.	2. During this description of Matthew's very difficult behavior, the therapist was wondering whether she should ask the parents to control Matthew and, if so, when.
3. The father agrees that he is worried about the effect on the whole family. He thinks that there is a problem because he does not get on with, or is not very close to, his son John. He then says that he does not have very much patience and smacks Matthew fairly quickly if he does not obey. In this way, like the others, he is giving thought to the family's problems. In being asked about the reasons for the lack of closeness with John, the father brings in the fact that his mother-in-law has always lived with them and has intruded on them, stopping them from being a family.	3. The force of family response in relation to the issue of the grandmother indicated this to be of major emotional importance and a salient aspect of both current family life and of the conflict within this family. There was a suggestion that the grandmother's role may be important in relation to the problems of controlling each of the children successively. The therapist picked up the mother's statement of the family being a "four-generational" one and felt that this may be perceived as a major problem in the family—because of the difference in age.
4. The mother enlarges on this and describes the grandmother as "the missing person" who has always lived there. The family lives in her house and are all quite involved with her. The mother described how Matthew will go upstairs with his grandmother when he has been chastized by his mother. Meanwhile, Matthew is roaming around the room and shouts hello at this point as if to an unseen person. In a very lively way, the mother proceeds to describe, backed up by the family, the problems of sharing space with the grandmother, who has more space for herself in the house than the four of them have. It is a shared house but the grandmother regards it as all her own.	4. Space is clearly a central issue, and is illustrated by Matthew's wandering about the room.

Account of Interview—Section of First Interview	*Comments of the Therapist*
5. The mother described the problem of living with "four generations," and when therapist asks what this means, the mother lists Matthew at 5, John at 17, themselves, and the grandmother at 75. Matthew has really been hitting and provoking John for some time. John playfully fights back and at this point the father interrupts and tells John to stop.	5. Although Matthew had been the obvious provoker, it is John who was reprimanded, which says something about who controls and whose behavior gets controlled. The children seemed to ignore the parent's expectations by using the relationship to the grandmother as an alternative and perhaps more powerful parental figure. Matthew used the opportunity created by criticism of John to try to push him out in order to get close to his parents and to make John into the bad one.
6. The mother then goes on to illustrate how the grandmother holds the family for ransom by suggesting they are trying to get rid of her whenever they suggest any minor changes within the house, for example, of furniture. Periodically, Matthew stops his running around and lies across his mother's lap.	6. Matthew is perhaps trying to comfort his parents and to respond to their frustrations.
7. The therapist then asks the father what he thinks the grandmother might worry about and he agrees with his wife, adding that he feels under a particular obligation not to move the grandmother out or to ask her to move because he bought the house from her. At this, the mother adds, rather angrily, that her mother has the biggest rooms in the house. Matthew makes faces at the camera.	7. The therapist ignores Matthew's running around the room. This is accepted as a model by the family, which likewise ignores Matthew. The urgency in the mother's voice is responded to by the therapist, who gives reassurance. The therapist keeps a balance of contributions by turning the mother's questions to the father. The session continues in further exploration of the relationship with the grandmother and of the father's family until the therapist brings the first part of the consultation to a conclusion.

The therapist needs to review these phenomena as information, to maintain self-command, and to so shape interventions as to handle them either directly or indirectly. Flexible integration of all the therapist's experiences into the therapy process remains the guiding principle. By contrast, the narrower approach lends itself to reliance on the therapist, perfecting a limited range of interpersonal skills and interventions that deflect or protect against deep involvement.

Structuring the Therapy

The primary aim of therapy is to meet the needs of the family. This aim must be put into the context of the therapist's capabilities, his or her interest in the family, and the techniques that he or she uses habitually or needs to develop (if still in training). The focal approach demands consideration of the system being treated, the system giving treatment, and the way these interact. As far as the system being treated is concerned, it is important to bring in any agent that has a direct accessible interacting role with the family in relationship to the problem being presented. For example, in the G. family alluded to, in the problem of the 5-year-old presenting with obesity, overactivity, and aggressive behavior, the grandmother was a key actor; in cases of family breakdown, a child-care professional or a foster family may need to be included. In other cases, of course, the presence of a grandparent in the home or involvement of other professionals may be irrelevant to the family's problem and these individuals would not be included in therapy.[10]

Sometimes a part of the family system may be worked with, for example, the marital couple alone or an individual. In the case of Richard in

[10] *Editors' Note.* We wish to underscore that it is quite possible for the family therapist to work with a broad network of "patients" or others in the family's life and yet still maintain attention to the dynamic (psychodynamic) meanings of symptoms and of interaction. Rather often of late, we think, family therapists have seemingly come to believe that using a wide-angle lens on the family precludes high resolution.

I *Family and Professional Network Composition (Age, status, occupation, presence/absence)*	*II* *Current Complaint (Duration, nature, complainant)*	*III* *Reported Past Events, States, and Relationships in: (a) Previous family system*	*III* *(b) Current family system*
Hans, 42 German parents. Supervisor on railroad.	Feels he is not close enough to his eldest son, John, because maternal grandmother intrudes between them.	Considerable secrecy about father's family. His father (PGF) was a prisoner of war who died in a shooting accident but father was told he died in the war. His mother (PGM) then married a Russian, who adopted him and PGM divorced him and remarried. There was an older brother, who died.	Parenting has been shared between parents and MGM. Before Matthew's birth, there were marital problems between the parents. MGM did not expect another child because of mother's gynecological problems. The parents, in fact, planned him. Relationships between parents and MGM then deteriorated. Mother tries but fails to stop MGM's giving Matthew fattening food.
Margaret, 38 Housewife	Tension with maternal grandmother because of her intrusiveness.	Mother's father (MGF) died when she was 15. He was easy-going and her mother (MGM) was dominant. Quarrels ensued if MGF tried to challenge MGM. He was the only one who could. It was only possible for mother to cope with MGM by passivity. Mother had one brother with whom she did not get on.	
John, 17 Working	Unhappy at work.		John had similar weight problems until he started using a bicycle at 10. He has also had learning problems and needed remedial help. He has been an anxious boy.
Matthew, 5 At school	Obese, excitable, overactive: the mother is afraid he will hurt someone at school because of his size. School finds handling him a problem. Family cannot control his behavior or his eating.		
Maternal grandmother, 75 Shares the family home (All family members are English-born)		Maternal great-grandmother lived in the house when mother was growing up. Sacrifice by children was called for without complaint in that household.	The family bought their home from MGM 13 years previously and she continues to live there. She has retained as much space as the rest of the family put together.

IV *Surface Action* *Reported (Current family life and relationships)*	*IV* *Surface Action* *Observed (Explicit, typical behavior)*	*V* *Meanings Active in the Family*	*VI* *Handling Meanings, and Past Events*	*VII* *Requisite Changes*
	Father is also overweight.	Major secrets are present and there is no way of discovering them.	Matthew's activity may represent the family's wish to be active in relationship to MGM and to pursue the family's desire for space.	1. Matthew's overweight to be reduced, eating to be controlled.
All the family enjoys eating. Father feels he and his wife are now too far apart. Father and John are disappointed with their jobs. Mother is helpless and tries uselessly to control Matthew by shouting and smacking. He persistently interrupts his parents.	Both parents seem depressed and hopeless. The family atmosphere is rigid and flat. Matthew's lively, provocative behavior contrasts with the rest of the family's unhappiness.	Assertive activity, like control, can be violent and lead to a painful loss.	Compliance may be necessary now because assertiveness in the family of origin was associated with violence and loss.	2. Parents to be able to (a) manage Matthew's behavior and (b) enjoy activities with him.
	Matthew claims he is older than his age.	There is no great pleasure in work or school.	Secrecy is maintained and disasters (e.g., shooting) are not revealed.	3. Father and John to enjoy more activities together.
The boys share a room and irritate each other. However, John has taken a younger boy under his wing and Matthew likes older children. Matthew can be good with John.	Matthew fights John when loss is discussed. Matthew is intrusive, uninhibited, and talks over the therapist. The parents respond passively to this.	Overeating is the tip of the iceberg.	History repeats itself in that mothers and daughters must live together even when they marry. But mother attempts to reverse it by seeking help.	4. Parents to be in charge of children and MGM to be noninterfering.
	Family expresses sadness at the absence of MGF, because 'he would control MGM.'	Children cause separation of parents.		5. More satisfactory living conditions to be negotiated with MGM.
Maternal grandmother fears that she will be moved to a house for the elderly. She allows Matthew to eat with her, as John used to. John still goes to her to avoid household chores.		It feels as if there are four generations in the family.		6. Parents to enjoy joint activities.
		Daughters who have marital problems look after their mothers.		7. All members to be appropriately assertive.
		Grandmother feels that she will be got rid of and so takes a hard attitude.		

Figure 9-10. Focal formulation of the G. family

1. *How do symptoms fit into family interaction?*

   Parents can control neither their children nor their dependent grandmother and turn to outside professionals.

2. *How would the family interact without the symptoms?*

   Without outside help, there would be violent confrontation across generations and between the parents.

3. *Why is the speculated interaction avoided?*

   Loss by death due to violence or suicide, or by extrusion.

4. *How is this linked to past events?*

   Both parents lost fathers and as children had to look after their parents without being able to complain or confront them.

Summary

Inability to control or complain to dependent relations requires outside help to avoid confrontations that would otherwise lead to violence and loss.

Figure 9-11. Focal hypothesis for the G. family

the L. family, the mother was offered some individual therapy simultaneously with the family work because the pervasive traumatic experiences of her childhood and early adolescence appeared to dominate the family. In most such cases, a single therapist is generally sufficient. However, cotherapy is useful in cases with major legal or extensive societal involvement, such as child physical or sexual abuse, because of their complexity and the emotional pressure that develops during therapy.

A therapy supervision team is useful, and is essential during the training of therapists where the forms, documentation, descriptions, and development of interventions require discussion and explication. Other therapeutic approaches use a team regularly, and we, too, believe that teamwork remains useful whatever the experience and ability of the therapists. There are several methods of observation: sitting behind a one-way screen, sitting in as a noninvolved observer, watching by closed-circuit television, or viewing videotape subsequently.

Our approach derived from those methods developed because of the shortage of time available for individual psychotherapy, and because family work was believed to be more economic. We have observed over the years that, unlike in individual therapy, there is little inherent tendency for family therapy to persist without purpose. The effort of organizing the family to come to therapy, and the fact that attendance leads to venting stresses in a public way, usually means that once sufficient change has occurred, there is a desire to terminate. It has, therefore, not been necessary to regard formal time limitation as an inherent aspect of the approach. Typically, cases may be seen at three- to four-week intervals over six to nine months. However, there may be factors in a particular case that call for a time limit to be set, as in testing the rehabilitational potential of an abused child. Family circumstances, such as travel abroad or a parent whose occupation causes extensive absences, may also dictate the time available. The natural long-term development of the focal family approach is that one (or more) individuals within a family become aware of personal traumatic experiences and circumstances that may lead them to choose to have a period of individual treatment to assist in their longer-term personal growth. Emotional growth in the case of a child may require separation from the family or attendance at a special school. Sometimes, other treatments are part of the context of family therapy. For instance, marital partners may each be in separate group treatment and need to do some family work on their shared problems.

The time gap between sessions often fluctuates, depending in part on the techniques being employed. For instance, if a structural technique such as setting tasks at home is used, then frequent sessions may be necessary, possibly at weekly intervals. At the other extreme, a strategic–systemic intervention that focuses on the impossibility or inadvisability of change may require a longer interval between sessions.

In academic and educational centers, technical issues may not be dictated by the needs of the family alone. Our view is that the fully trained therapist needs to be able to use a variety of techniques and to administer many different forms of intervention. Hence, there may be periods during training when a therapist deliberately practices structural techniques and sees families at shorter intervals.

The Role of the Therapist

Our approach contrasts with some therapeutic approaches where the role of the therapist is clearly defined. For example, a structural family therapist automatically assumes a role as the leader of the family system, clarifying goals and taking control of the session. The therapist does have to take a highly active role in the early stages in order to make an assessment and later may do so when testing whether criteria for improvement have been met. However, during therapy, the therapist's behavior may vary enormously. He or she may overtly control sessions on some occasions and be highly active and directive, even explicitly taking responsibility for bringing about changes. At other times, however, the therapist may appear to abdicate responsibility and allow the family to be in control. On occasion, the therapist makes himself or herself the center of a communication system and at other times facilitates and encourages family members to talk with one another. There may be occasions when self-disclosure is an important intervention; on other occasions, he or she may maintain an attitude of secrecy or neutrality in terms of his or her own views. The therapist's role may evolve as therapy progresses, or there may be radical changes from session to session.

Since our approach emphasizes response to the family's need rather than adherence to the therapist's technical theories, the prime goal in training is to develop flexibility in dealing with the family. A therapist must value and use a variety of skills and techniques and must value and appreciate other (nonfamily) modalities of treatment.

An ability to develop and articulate an imaginative theory of the family, the focal hypothesis, is primary. The focal hypothesis needs to be maintained (or specifically modified) throughout the process of therapy, as it acts as the terms of reference for all activity and for evaluation of results. In order to keep therapy on track and to enable clinical research, we have developed a specific process instrument called the Focal Therapy Record Sheet.

The Focal Therapy Record Sheet

We have repeatedly emphasized that our approach is to separate assessment from the therapeutic process itself. This is true not only when instituting therapy, but also on a session-by-session basis throughout therapy. With the focal formulation and hypothesis as a frame of reference, it is necessary to identify the main priorities for attention and intervention from session to session and to develop a strategy for action with the family (Kinston, 1986). In the session itself, the therapist needs to handle whatever the family presents with sensitivity and needs to respond to it naturally, while still pursuing his or her strategic aims. Tactics, therefore, should be flexible. Occasionally, a strategy may have to be abandoned. However, if the therapist is repeatedly deflected from his or her strategy, then something is missing from the focal hypothesis, or alternatively, the competence of the therapist in this case needs to be questioned. At the completion of each session, it is necessary to assess what has happened, what new has emerged about the family to elaborate or disconfirm the focal hypothesis, and which of the requisite changes have been made.

To facilitate this rational approach to the therapeutic process, we devised the Focal Therapy Record Sheet (FTRS) for completion by therapists. It is laid out in seven columns, as shown in Figure 9-12.

1. Therapist's Aims

This column should be completed just prior to the session or immediately after the end of the previous session. The therapist records his or her aims and plans for the sessions and any key thoughts. For example, in the initial stages, aims may include gathering information about the family, further conceptualization of family dysfunction, clarification of practical points about the setting of therapy, and so on. Later, the aims may be to test the focal hypothesis or to produce a particular change in family interaction or in family meanings. The therapist also notes here any technique he or she intends to use. Aims may be described in the form appropriate for this technique.

Therapy will be neither brief nor focused if

the therapist does not make preparatory plans for each session. Unfortunately, in busy clinics, it is only too easy for this essential discipline to be omitted.

2. Family Feedback and Intersession Events

Feedback from the family about previous interventions and reports of intersession events can give important information about change, difficulties in changing, new problem areas that have arisen, or the appropriateness of the therapist's intervention in the previous session. Family feedback coupled with the therapist's preset aims for the session form the combined, basic starting point for each new session.

If the feedback is unexpected and does not fit with the preset aims, the therapist may have to readjust these aims immediately. Such incongruity may be due to family factors or therapist factors. Family factors include new information about salient events that change the direction of therapy and apparently randomly intervening events such as sudden illness, unexpected redundancy, or an accident. Therapist factors generating incongruity include insufficient assessment and conceptualization and inappropriate or unskillful application of techniques.

3. Content Related to Focal Formulation

This column should document the unfolding of the session and include the main details of the family interaction and information reported in the session. The material under this heading serves as a brief clinical summary of the process of the session. Inferences about the effect of intervention do not belong here.

4. Information Relevant to the Focal Formulation.

As the therapist's comprehensive understanding of the family deepens, his or her aim and plans and methods of intervention will alter. It is, therefore, important at each session for the therapist to note explicitly the emergence of new data relevant to the focal hypothesis. This is part of a continuous reassessment of the family dysfunction and fine-tuning of the system model that is being used.

In this column two types of information are distinguished:

a. New information that enlarges an already-known problem area. This may add to the understanding of the mechanisms or rules the family or family members use, or it may have implications for tactics and techniques to be used.
b. Any new information that demands a qualitative alteration in the focal formulation.

5. Area of Focal Formulation Worked On

This column reflects the fact that in any session there will be many areas of the focal formulation on which the therapist could potentially work. Explicitness about the area of the focal formulation actually being dealt with in the session allows the therapist the check whether:

a. Work in the session is still in line with the focal formulation.
b. The problem areas judged to be relevant are indeed tackled in the session.
c. The criteria for improvement in the area on which the therapist has worked in the session have been met.

6. Therapists' Strategies and Interventions

The therapist records here the strategy and main techniques and tactics used during the session together with the family's response. Any tasks for the family to complete between sessions are also recorded. It is possible to use this column to check that the therapist is intervening in a consistent, persistent, and therapeutically logical fashion in successive sessions. Comparison with prespecified aims (column 1) checks whether the therapist's direction has been maintained within a session.

7. Criteria for Improvement Met

Improvement in the family requires symptom loss and a variety of changes in interaction as laid down in the focal formulation. The therapist notes here any improvements that have occurred according to these preset criteria. Successful therapy demands maintenance and consolidation of change, so the same or similar but progressively greater achievements may be recorded over several sessions. This column, therefore, provides a form of continuous outcome evaluation, which has proved to be far more satisfactory than conventional snapshot assessment.

At the end of each session, the improvements made can be compared with the aims (column 1) and with improvements noted in column 7 for previous sessions. This enables a check on the course of therapy and assists in the choice of aims for the subsequent session.

The use of the FTRS was illustrated in detail by Furniss, Bentovim, and Kinston (1984). This paper used the case of Nikos in the J. family, referred to earlier, to lay out the entire process of therapy. The early phases of the therapy used structural techniques that aimed to deal with Nikos' disruptive behavior, calm him down, and assist the parents to gain control. We had concluded that taking control in this family meant taking responsibility for the handicap and that Nikos' role was to ensure that the parents would be protected from this. In sessions 9, 10, and 11, therefore, the therapeutic goal moved to reframing Nikos' disruption to the family as helpful rather than as a hindrance. The therapist informed the family that "Nikos thinks he has to help them by creating a minor disruption so his parents will not have to talk about painful matters." The focal hypothesis also specified that the parents felt the handicap was due to their marital conflict.[11]

Details of two important sessions, 13 and 14, are given in Figure 9-12. As well as illustrating the use of the FTRS, the material also demonstrates two key aspects of our approach. Session 13 describes the deterioration in family functioning that accompanied the emergence of the trauma and preceded the final working through of the focal hypothesis. In session 14, the therapist decided to see the parents alone, illustrating that work can move to a part of the family. After this watershed, the therapy was terminated at session 16, with the therapist able to record that most of the criteria for improvement had been met.

The FTRS is also an educational and research tool. As an educational tool, it provides the necessary discipline for development, thinking, and reflection. As a research tool, it enables meaningful clinical studies, for example, into the basis for using particular techniques or strategies.

We have noted, for instance, that clinical practice and techniques used in marital cases follow a different course from those used in child-sexual-abuse cases. The opening phase in the former typically involves problem definition and the exploration of the family of origin through genograms, and sculpting to release emotion and begin the creation of a new reality (Bentovim, 1990). The opening phase in sexual abuse typically involves establishing the reality and extent of abuse, encouraging acceptance of responsibilities for acts, and strengthening the relationships between the nonabusing parent and the children (Bentovim et al., 1988).

An Illustrated Case—The G. Family

[See Figures 9-10 and 9-12 for the Focal Therapy Assessment Sheet]

Following the diagnostic interview with the G. family, six family sessions were held, the final session occurring eight months after the first. The long intervals between sessions were due to the family's repeatedly canceling appointments, ostensibly for reasons of ill health. However, on at least two occasions, it was clear from phone conversations that there was resistance to attending. Although, in some situations, regular attendance by all or some subset of members might be compulsory (e.g., in abuse or major breakdown work), in others, such as this one, any attendance at all was regarded as an achievement. John, the older boy, did not attend any session after the first. Both parents came with

[11] *Editors' Note.* While all this recording may at first strike the reader as cumbersome and burdensome, note that these entries are typically very brief and would appear to require no more time than what is ordinarily needed for the entry of typical "process" or "progress" notes in a family's clinical charting record.

1. Therapist's Aims	*2. Family Feedback and Intersession Events*	*3. Content Related to Focal Formulation*
SESSION No. 13, Week 26		
Explain that the discussion about blame and guilt had to be avoided because of the parental belief that the handicap was caused through marital conflict before the boy's birth.	Parents did speak with each other at home about problems with the children. (Task set in session 10 now accomplished.)	The parents talk about Nicos' future and their hopes of a 'miracle drug' for his hyperactivity. Nicos is very tiring for the parents; only the parents or Kate can look after him and they fear that this will always be so. Parents say they have been coming to therapy for too long.
SESSION No. 14, Week 29		
(Parents only) Find out what first made the parents see that Nicos was handicapped. Reassess Nicos' handicap.	Father reports that the parents communicate much better and that Nicos is still the problem.	Mother first blames herself for not having done enough for Nicos concerning school and medical care. She feels guilty about his handicap. Father blocks the subject of guilt and diverts the talk to drugs, then to schooling and the value of a boarding school. All problems are projected into the future. Then the parents start talking of the time around Nicos' birth and mother breaks into tears. She feels that he would be different if there had not been the conflict between her and her husband. Mother expresses pain about realizing that Nicos is handicapped. Parents share pain. Lack of communication acknowledged as reason for insecurity in the marriage.

Matthew to the second, third, and fourth; the mother and Matthew came alone to the fifth and sixth. Despite considerable effort, including letters from the therapist, the maternal grandmother did not attend.

The aim in presenting this case is to demonstrate a typical conventionally documented therapy from our clinic (although the FTRS is omitted here).

Second Session

The main aim was to strengthen the bond with the family to continue exploration of family patterns of behavior, and in particular to elucidate implicit rules that governed interactions. In pursuing this, further family history was also obtained. Both parents talked more of their own experience of emotional deprivation, in particular, their shared experience of having had little positive demonstration of affection from the parent of the same sex. The therapist specifically empathized with their past pain. The parents were then able to talk of the deprivation expe-

4. Further Information Relevant to Focal Formulation	*5. Area of Focal Formulation Worked On*	*6. Therapist's Strategy and Interventions*	*7. Criteria for Improvement Met*
Parents were very reluctant to continue to talk with each other about marital problems. The attempt to bring back Nicos as the only problem is indicative of the great anxiety about opening up marital conflicts.	Parents' unrealistic views of Nicos' handicap. Parents' reluctance to think about the time of Nicos' birth.	*Structural:* Therapist accepts parents' reluctance to talk. Therapist suggests that the parents should come on their own to discuss help for them as parents of a handicapped child.	Definite deterioration: parents less able to talk about their problems than expected.
Father gets blamed not only for the parental conflict around the time Nicos was born, but also for the handicap.	*Active meaning:* Marital conflict prior to birth of a handicapped son as the original precipitating stressful experience reflected in the parents' dysfunctional interaction.	*Dynamic:* Therapist's interpretation of the wish for a "wonder drug" to make Nicos normal leads the parents to refer to his birth. The therapist then explores original conflict around this time.	Commencement of shared mourning for the handicap.

Figure 9-12. Example of part of a focal therapy process record in the J. family

rienced by the grandparents, in particular, the childhood hardships of the maternal grandmother, hitherto presented in a predominantly unsympathetic and negative light. The repetition of the pattern of daughters caring for their mothers emerged and was explicitly identified by the mother as "falling into the daughter–mother pattern."

In both families of origin, inconsistent discipline was described and also difficulties in dealing with conflict between the grandparents. In addition, there was a strong prohibition in both families on direct criticism or any expression of anger. Negative feelings had to be suppressed. In the mother's words, "I had to draw a cocoon round myself and swallow feelings." The father was also inhibited, perhaps because of the mysterious violent death of his father. He could hardly bear to discuss the possibility of feeling angry with members of his family. Not surprisingly, both parents were unable to be explicitly aware of their anger at the maternal grandmother. Significantly, Matthew's only spontaneous interjections occurred when the family spoke about family tensions and described minor arguments.

The factual information about past experience was gained directly, whereas information about the rule of not expressing anger was gained by circular questioning, for example, "Who would be most angry with grandmother for feeding cake to the boys?" Matthew's resistance and refusal to speak were not challenged but were accepted by the therapist as a reasonable option, and were then ignored. The purpose here was in part to model for the parents a refusal to get drawn into conflict and in part to connote his behavior as appropriate.

At the end of the session, the final therapeutic intervention was to connote the family rules positively. In swallowing their feelings and sacrificing their own needs to care for those in other generations, the family members were praised as protective and able to deal with their conflicts.

Intersession Contact

The mother phoned twice to cancel sessions because of illness. She vividly described worrying behavior by Matthew, such as climbing on roofs, running about dangerously, and striking other children. She conveyed a sense that he was almost beyond his parents' control. At one point, the therapist asked the mother if she was expressing her own fears of Matthew's coming to harm if he stayed in his family. After an initial furious response, the mother calmed down and acknowledged the reality of the dangers she was describing, although she said she was sure that she wanted Matthew to stay in the family. In one conversation, the therapist emphasized that Matthew's safety and physical health depended on ensuring that he did not overeat.

Third Session

In this session, the first strand of the hypothesis was actively worked on, namely, not feeling in control. At the start of the third session, the parents described their success in getting the grandmother to stop feeding Matthew. They attributed this change to the grandmother's feeling threatened by the invitation to attend family therapy. The therapist wondered whether the mother might not have been firmer with her following the phone conversations. The potential self-destructiveness of Matthew's behavior was further discussed. The parents were asked to discuss what realistic expectations they would have of a 6-year-old in relation to tidying up at bedtime, this being a particularly difficult time for the family. With great difficulty, the parents agreed on some expectations and on ways of managing this period in the future. The therapist encouraged the parents to spend time in enjoyable activities as a reward for Matthew's compliance. This was advised particularly to assist the father, who had talked at the initial interview of his feeling of loss because of not having a close relationship with the older boy. Some tasks and rewards were explicitly set for the family to carry out at home to support the work of the session. Charts and diaries were to be used to check compliance. The therapist used predominantly structural and behavioral techniques in this session.

Fourth Session

This session was held three months after the third. The family members did not bring their star charts and diaries with them. Matthew, as before, separated himself and sat quietly writing. The parents initially gave positive feedback, describing Matthew's bedtime behavior as much improved with their new management. However, it soon emerged that this improvement had lasted for several weeks but had not been sustained, largely because the parental management had not been consistently continued. In addition, the mother had been physically ill for much of this period.

As the therapist explored the events of the more recent weeks, the interactions in the family became increasingly dysfunctional. Tension between the parents rose, partly over their management of Matthew, but more because of their concern as to how to manage when the mother was ill.

These phenomena (disorganization, rising tension, illness) suggest that the trauma is being reached. The father insisted that the mother had to look after herself, as well as the house and the children, because of his long working hours. However, he clearly felt guilty about this, and his wife felt uncared for, despite her awareness of his work pressures. At this point, Matthew came to their rescue, interrupting and

seeking attention in a variety of disruptive ways. The parents were inconsistent; for example, the mother complained verbally of his general behavior but hugged him during the session and appeared to encourage it. The therapist used the interaction to help the parents to contain and manage Matthew. For example, he got them to agree to how they wanted Matthew to behave and pressed them to enforce it. At this point, the father became angry about being "psychoanalyzed" and walked out of the session, taking Matthew with him. Left alone, the mother claimed that her husband had left because he felt upset and guilty about not being able to care for her when she was ill. She wished to continue coming to therapy and thought she could persuade her husband to come with her.

The therapeutic tactic had again been predominantly structural and confronting. This is not usually appropriate to facilitate the reworking of a trauma. The family had strongly resisted this approach and the consequence of confrontation was enacted. The family split up. The family had mentioned a neighboring family whose children were taken into foster care because of inadequate parenting, and it might have been more helpful to approach the family psychodynamically, talking more of the needs, the past, and secondary fears rather than trying to restructure. This issue of children being abused and poorly cared for was felt to be too sensitive to link directly to the parents' fears. The therapist agreed with the mother's opinion that the father had been more upset by describing what he felt as noncaring in the marriage than by a failure to control his son. In view of the history of broken or unsupportive marriages, this is not surprising. The known trauma and disasters were losses within marriage and not loss of children.

Fifth Session

The mother and Matthew came alone to this session. The need for psychodynamic intervention with respect to the third element of the hypothesis was now clear. However, to set the scene, Matthew required controlling without excessive confrontation. The therapist set up a structured task in which the mother was helped to get Matthew playing without interrupting for five minutes and then a reward was provided. In the course of doing this, and discussing its use at home, the mother's style of communication was noted and fed back to her. She and her husband avoided asserting their own wishes and instead talked in a way that deferred to Matthew's opinion or invited comment or disagreement. The mother then described her past sadness at not being able to mother Matthew closely as a baby because of her hospitalizations for serious illnesses. She expressed her mixed feelings at the loss of her own independent working life as a result of late pregnancy. Her ambivalence and her sense of loss and of failure at mothering were linked to her current difficulty in being appropriately firm with Matthew. The interventions appeared to relieve her guilt and self-blame.

Sixth Session

The mother and Matthew again came to the session without the father. In this session, there was a marked difference in Matthew's behavior. For the first time, he was positively friendly to the therapist and the mother reported improvements in her management of him and in his behavior. She disagreed with the therapist on some points in a healthy and self-assertive way. She had shared the tasks set by the therapist with her husband and also had involved him in helping her to develop a clearer way of conversing. She noted that his speech was also inconsistent, and the therapist had also noted this in the sessions. She conveyed the impression that she had actually wanted the sessions for herself alone. As the caregiver to two other generations, she was in touch with her own need for care. The therapist, therefore, offered a short period in an intensive day unit using the excuse of giving her more time to practice her new ways. However, she refused. She ended the treatment by saying that she knew that she could request further help if she wanted to in the future. She felt that Matthew was much improved and reported that the older boy's work and social life were more satisfactory. Her husband had the possibility of changing jobs, which might enable to family to move and so redefine the amount of space to be set aside for the grandmother.

Requisite Changes

As regards the requisite changes, Matthew's obesity had progressively reduced over the last six months and the grandmother had stopped interfering in his handling. We had both reported and direct evidence that the parents were able to manage Matthew more effectively and to enjoy some activities with him. However, the father was still doing this infrequently and inconsistently, and little change was reported in the relationship between the father and John. John himself had probably improved somewhat. There were no changes in the living arrangements, but there was less tension among the three generations and more acceptance of separate needs. A potential change of housing was on the horizon. There was no change in the time spent together by the spouses, but the bond between them had real strength in that they supported each other in times of stress and had been able to work together on some of the parenting problems.

CONCLUSION

The principles of our approach may be summarized as follows:

1. The approach is developmentally oriented and considers the health of the family in the context of its life cycle within and across generations.
2. The approach is rooted in the explicit offer of therapy and is, therefore, oriented to detecting possible family disturbance.
3. The family is viewed as a system that has human beings as its components and that is embedded in a social context. Therefore, purposes, feelings, and meanings are critical factors in any formulation of a family's situation, and culture is a critical constraint.
4. Traumatic events are the prime originator of disturbances that lead to families' seeking professional help. Traumatic events on individual, family, or social levels are events associated with intense anxiety and helplessness. They cannot be talked about and are represented by repetitive patterns of action that are dysfunctional.
5. Therapeutic work has to change patterns of action as well as meanings. In other words, the family both has to change its way of being and has to gain an understanding of how the dysfunction arose.
6. The therapist needs to be maximally flexible in the use of techniques and decision rules as he or she pursues a strategy that will release the family from its habitual dysfunction and enable it to create a new reality.
7. In carrying out therapy, psychoanalytic understanding of mental life is invaluable and therapist self-awareness is essential.
8. The detailed model involving focal hypothesis and formulation and the mode of recording described are generally applicable. (However, notwithstanding this claim, in certain cases, assessment will reveal that a simple response to the complaint may be all that is required.)

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